Motivational Interviewing
TRAINING · RESEARCH · IMPLEMENTATION · PRACTICE
MITRIP

Welcome to *MITRIP*

Allan Zuckoff

Dear Readers,

It is our great pleasure to present to you the inaugural issue of *Motivational Interviewing: Training, Research, Implementation, Practice,* the journal of the Motivational Interviewing Network of Trainers (MINT).

From 1994 through 1999, under the founding editorship of David Rosengren, the *Motivational Interviewing Newsletter for Trainers* served as the primary vehicle for communication among members of the newly formed International Association of Motivational Interviewing Trainers (IAMIT). In 1999 the organization took the name of Motivational Interviewing Network of Trainers (MINT) and a closed listserv, restricted to members, was established. In the face of these changes the newsletter was renamed *Motivational Interviewing Newsletter: Updates, Education and Training (MINUET).* Denise Ernst took over as editor, followed by Ralf Demmel in 2002 and Allan Zuckoff in 2004. During this time, the *MINUET* continued to serve as a vehicle for distributing conceptual articles, international updates, and distilled summaries of some of the topics discussed on the listserv. In 2005 the publication was renamed *MINT Bulletin,* in recognition of its evolution from newsletter to venue where readers could find new ideas and conceptual frameworks, accounts of training experiences and novel training exercises, descriptions of current trends in MI research and work in progress, and advances and struggles in MI practice, all put forth in a spirit of "dialogue without diatribe, critique without competition."

By 2009 it had become apparent that the publication was ready for its next leap forward and a working group of MINT members was convened to consider the *Bulletin* of the future. That working group evolved into the editorial board of a new journal, which would expand its pool of authors from members of MINT to all who wished to contribute while maintaining a spirit of openness, informality, and shared respect for the MI community and for the counseling approach that brings us together. In February, 2010, the final issue of the *Bulletin* announced our arrangement with the University Library System of the University of Pittsburgh to publish an open access journal online, introduced the editorial board, and predicted that the first issue would “go live” later that year.

As so often happens in the glow of enthusiasm at the launch of a new endeavor, we significantly underestimated the complexity of the task we were undertaking and the time it would require us to complete it. Nonetheless, two years after our first public announcement, we hold to our mission of providing an outlet for articles of interest to the worldwide community of practioners, trainers, and researchers of motivational interviewing, as well as a virtual space where members of MINT can communicate with each other (and the wider world) about their experiences related to the ongoing development and dissemination of MI.

Motivational interviewing is a living, dynamically evolving approach to counseling, whose ongoing development is a product not only of the relentless innovation of its founders, William R. Miller, PhD, and Stephen Rollnick, PhD, but also of the creativity in training, research, implementation, and practice of thousands MI aficionados in dozens of countries and languages. We welcome your comments and contributions and hope you will find our journal a reflection of that open and creative spirit that characterizes MI as well as those who are drawn to it.

ISSN 2160-584X (online) Vol. 1 No. 1 (2012) DOI 10.5195/mitrip.2012.5

Motivational Interviewing
TRAINING · RESEARCH · IMPLEMENTATION · PRACTICE
MITRIP

MI and Psychotherapy

Wlliam R. Miller, PhD[1]

Abstract

How is motivational interviewing (MI) related to psychotherapy more generally? In its original formulation MI was intended to address the specific problem of ambivalence about change. It was not designed as a comprehensive psychotherapy or model of change. Subsequent clinical experience, however, suggests ways in which the spirit and method of MI may be useful throughout processes of change. Implications for a volitional psychotherapy are considered, with additional discussion of clinical applications of decisional balance.

Keywords

decisional balance, motivational interviewing, person-centered, psychotherapy, volition

As my title implies, I am going to address the interrelationship of psychotherapy in general with motivational interviewing in particular. I enjoyed preparing this presentation and thinking through some of the issues involved. How does MI relate to psychotherapy in general? Can MI be a broader psychotherapy? Does one step into and out of MI? How does all of this relate to a person-centered approach? I will reflect on these issues, with a detour into the therapeutic use of decisional balance.

MI was never meant to be a comprehensive system of psychotherapy. We developed it as a specific method for addressing a particular clinical situation. That is the situation where a client needs to make a change but has been reticent to do so. That is a complex situation in itself. What does it mean that the client "needs" to make a change? The client may overtly acknowledge the need, but seem stymied in getting on with it. MI is certainly appropriate in that case, but there is another common scenario in which it is apparent to the clinician but less so to the client that a change would be in the client's best interest. The prototypic case for MI is the one for which I originally developed it: people with alcohol problems who do not seem "motivated" to make a change in their drinking. They may even present as quite committed to continue drinking, themselves seeing no need for change, a situation that is more common when people are coerced into treatment. In the latter case, to which Prochaska and DiClemente refer as "precontemplation," they truly are not ambivalent about drinking, and the therapeutic task is to begin to raise some doubts, to *create* some ambivalence. My own experience, though, is that even among those mandated to treatment, most are already well aware of both pros and cons.

That scenario, of the person insufficiently motivated for change, is a common one in health care practice, but it is only a small sector of all the tasks that a practitioner must address. The relative size of that sector can be debated. It can be argued that helping a person to *decide* to make a change is a substantial part of the clinician's task. The President of a large addiction treatment system was once asked what it takes to have such a successful program. He replied wryly, "Be the place where people go once they have decided to quit drinking." It is a good service to help people decide to change. Yet any clinician does much more than helping people to make up their minds.

That is why Terri Moyers and I argued, in our "eight stages" paper, that it is important to know when to put MI down (Miller & Moyers, 2006). Pick it up and use it as a tool when the task at hand is to strengthen motivation and commitment for change, but then move on. A clinician who uses only MI is like a restaurant serving only green chile stew—good stuff, but not exactly a balanced diet.

So why, then, is there even a discussion about MI as a more comprehensive therapeutic style, let alone a "way of being"? I think that the initial reasons are *intuitive*. Clinicians who become skillful in MI experience that in some sense they don't really put it down when the specific task of building motivation for change is done. They don't *want* to put it down, and it is something more than just wanting to keep this tool handy in case it is needed again. There is something about the spirit of MI, its *Menschenbild*, that seems appropriate, even optimal for the broader tasks of psychotherapy.

IS THERE A MOTHER SHIP?

Now the first thing that occurs to me is that the mother ship, the broader psychotherapy on which MI was constructed, is the person-centered approach of Carl Rogers (1980). There is overlap between the three elements of the spirit of MI—collaboration, evocation, and autonomy support—and Rogers' necessary and sufficient conditions for psychotherapy: accurate understanding, nonpossessiive warmth, and genuineness. There is also a difference in emphasis, to be sure, with the most obvious point of contact being accurate empathy, which is where the evidence of efficacy is strongest. Nevertheless it is possible to think of MI as a specific evolution of the person-centered approach, something that grew out of and shares most of its genes with Carl Rogers. One

[1] University of New Mexico

A version of this paper was presented as a plenary address at the MINT Forum, Albuquerque, NM, October, 2008.

The author reports no conflicts of interest.

Correspondence concerning this article should be addressed to William R. Miller, PhD. Email: wrmiller@unm.edu

ISSN 2160-584X (online) Vol. 1 No. 1 (2012) DOI 10.5195/mitrip.2012.6

could thus think of using MI as a specific tool and then stepping back into client-centered therapy as a broader approach.

One *could*, but that is not in fact what has typically happened. Clinicians have come to MI from many different psychotherapeutic perspectives, and blend it with their other clinical skills. My own training was in cognitive-behavior therapy along with, thank goodness, a solid Rogerian base. Psychodynamic practitioners find MI compatible, as do those coming from humanistic-existential, solution-focused, gestalt, family systems, and many other perspectives. All of these therapeutic orientations are represented within MINT. Then there is the fact that most MI practitioners these days are not psychotherapists at all, but practice medicine, social work, nursing, dentistry, health promotion, education—a plethora of helping professions.

There is also a somewhat uncomfortable fit of MI with classic client-centered counseling. Rogers specifically disavowed trying to steer the client's self-exploration in a particular direction. His student Charles Truax (1966), however, with the encouragement of Israel Goldiamond, maintained that this is precisely what Rogers was doing: differentially reinforcing certain kinds of client speech. He had five psychotherapists, naïve to the study hypotheses, rate therapist-client-therapist sequences from 20 of Rogers' own sessions, and found that empathy and acceptance were quite likely to follow certain types of client responses, but were unrelated to others. He also found that the types of client responses that were reinforced in this way were substantially more likely to increase over the course of the session. In other words, Rogers appeared to be differentially reinforcing client statements that favored change and positive self-regard. This is definitely not how Rogers understood his work. From a true person-centered perspective, MI might be seen as a genetic anomaly, an unfortunate mutation that departs from the nondirective heart of client-centered practice. So while the person-centered approach is in its own right a comprehensive system of psychotherapy, it may not be the mother ship to which we return after journeys of motivational interviewing.

Perhaps there is no single mother ship to which we all return. I think that is true. MI seems to be compatible with quite a few different perspectives and types of practice. A physician may adopt a guiding style to help a patient move toward health behavior change, then step back into the normal mix of directing and following. I originally thought of MI as a kind of preparation for treatment, something that could be added at the front end of many different therapeutic endeavors, and research now supports that symbiotic understanding of MI.

LESSONS LEARNED FOR PSYCHOTHERAPY

But let's take this a little further. Is there something that we pick up while learning MI that we carry back with us into our more general practice? Is there a broader therapeutic perspective that can guide both the use of MI and our clinical work more generally? I think so, and what I am expounding here is, I think, the product of this MINT community, something that is emerging collectively from our conversations.

First, the skill of accurate empathy transports well. Skillful empathic reflection blends nicely with and complements many other therapeutic methods. The more general perspective here is that people are worth listening to; that it is important to see the world through the eyes of the client, to understand and get inside that person's world. This is not only a pragmatic issue of making sure you get it right. There is great value for clients, too, in becoming clear about what they are experiencing. Both the clinician and the client are very focused then, and *prize*—place importance on the client's own experience. That is close to the heart of Rogers.

There is also clear consciousness that we are working with autonomous people, human beings who deserve respect and who can and will make their own choices. That undercuts a whole range of rescue and override fantasies that we may entertain, and lifts an enormous burden from the clinician's shoulders. Here the perspective shares much with existential psychotherapy and with self-determination theory (Deci & Ryan, 1985). It places emphasis on and attends to volition, the person's autonomous will to move in one direction or another. It is this acknowledgment of autonomy that renders psychotherapy a companionship, a partnership, a collaboration.

Beyond this sense of autonomous entities, I think there is also a trust in the wisdom of the person, that people do have within them the inherent will to be well and grow, and that it is our task to find and connect with that wisdom within. You may or may not go so far as the human potential movement's view of people as being inherently good and healthy. I personally believe that we all have potential for both light and darkness within us. The commonality, I guess, is knowing or believing that the light is in there, and can be found and nurtured in each person.

The tools of cognitive-behavior therapy come into play as means for self-determination. Carl Thoresen and Michael Mahoney (1974; Mahoney & Thoresen, 1974) saw this potential very early in the development of behavior therapy. There are things people can learn about how we work that can be useful tools of self-control. Thoresen reconceptualized the approach from behavior modification—something that an expert does to a passive client—toward teaching tools that people can learn for self-direction. That has, more or less, become a dominant perspective now in cognitive-behavior therapy, which focuses heavily on skill training for self-management. In MI, it is found in a shared avoidance of an expert fix-it role.

There is also, in MINT, a broadly shared value on testing our assumptions against and responding to research. This empirical approach is a means by which behavioral approaches established credibility as evidence-based methods. Rogers also valued an empirical approach, and in fact it was his group who pioneered use of the scientific method in understanding psychotherapeutic process and outcome. Just as we pose reflections to clients as hypotheses, so we also pose our own beliefs about therapy as hypotheses to be tested by the scientific method. We do not rely ultimately on armchair argumentation to decide issues of best practice, but subject our hypotheses to verification that others can share.

A SIDEBAR: THE GOOD THINGS AND NOT-SO-GOOD THINGS ABOUT DECISIONAL BALANCE

A timely and illustrative question pertains to the role of decisional balance in MI. In practice, it boils down to the question of how much time and emphasis should be devoted to intentionally evoking and exploring the client's arguments *against* change. There are at least two rival hypotheses here. One is that optimal practice is to thoroughly explore both the pro-change and the counter-change sides of ambivalence, within the humanistic trust that in doing so the client will move toward positive change. Within our original conception of MI, however, it would be contraindicated to evoke and explore the client's counter-change arguments, and one should differentially evoke and explore change talk as a way of helping the person get unstuck from ambivalence.

What research data do we have to bear on this issue thus far? First, the idea of counterbalancing pros and cons has been around for quite a while, and this relative balance is related to the transtheoretical stages of change. As people move through the stages, the pros of change grow stronger and the cons of change diminish. Or to reverse the equation: as

ISSN 2160-584X (online) Vol. 1 No. 1 (2012) DOI 10.5195/mitrip.2012.6

pros increase and cons decrease, people move toward behavior change. Thus the ratio of pros to cons is one index of readiness for change.

So what else is needed? Gollwitzer's version of the theory of reasoned action includes decisional balance as a *motivational* component, and decision as a *volitional* component. These, you will note, correspond roughly with Phase 1 and Phase 2 of motivational interviewing.

Reason ahead, then, to implications for treatment. This is a leap from correlation to experimental control. An intervention that strengthens the pros of change and weakens the cons of change should promote actual behavior change. Conversely, any intervention that strengthens the cons of change or weakens the pros of change should have the opposite effect. That is why, from the beginning in MI, we have maintained that it is countertherapeutic to argue for change, precisely because it elicits sustain talk from clients and thereby strengthens counterchange motivation.

Is it fair to make the leap from correlational-predictive findings to experimental intervention? I do think it is clear at this point that change talk as well as sustain talk and resistance are highly subject to influence by counselor style. MI increases change talk and decreases resistance.

The research on pros and cons as motivational markers also fits well with current findings in MI research. Both change talk and sustain talk predict behavioral outcomes, in opposite directions. The ratio of client change talk to sustain talk is a reasonably good predictor of behavior change, and from Terri Moyers' research with Project MATCH sessions, this may be true not only in MI, but in cognitive-behavioral and 12-step approaches as well (Moyers et al., 2007). In other words, there is a good bit of evidence that we're onto something in listening to client language, and it's not just epiphenomenal. It matters what clients say, and it matters what counselors say. I think that's good news for psychotherapists. If it didn't matter what we say, why are we doing talk therapy?

The picture changes, though, when we shift from decisional balance as a *predictor*, to decisional balance as an *intervention*. In a classic decisional balance, the therapist seeks to elicit and explore *equally* the pros and cons. No attempt is made to focus in particular on one side of the ambivalence. To the contrary, both sides are given equal attention, unconditional positive regard. The implicit hypothesis is that thoroughly exploring both sides of the ambivalence will lead to its resolution.

Here's an interesting study that is not experimental, but certainly relevant (Matzger et al., 2005). They interviewed 659 problem drinkers who at 12 months after treatment reported drinking a lot less than at baseline. At 12 months they asked them for the reasons *why* they had cut their drinking. Then they followed them over 3-5 years, to study whether they stayed in remission. And they specifically studied whether reasons for change were related to sustained remission. Only two reasons were associated with *reduced* chance of sobriety. One of these was being warned to stop (which from an MI perspective should elicit resistance). The other was weighing the pros and cons. Looking at it from a relapse perspective, weighing the pros and cons was associated with more than double the risk of relapse. So maybe weighing the pros and cons on your own is not such a good idea. What about doing it intentionally?

In another investigation by Prestwich et al. (2003), 86 university staff and students volunteered for a study to help them increase their exercise. They were randomly assigned to a self-monitoring control group, a group instructed to do a decisional balance, a group told to state their implementation intentions, and a combination of the latter two. Decisional balance by itself had no beneficial effect, but there were significant increases in exercise when it was combined with the implementation intention assignment that specifically directed attention toward change.

If do-it-yourself decisional balance is a little iffy, how about doing it with the help of a professional? A randomized trial done by Collins and Carey (2005) tested two forms of decisional balance: one done in an MI style, the other done in writing, each compared with a control group doing no decisional balance. There were no significant differences on any of four drinking outcome measures, and in examining the graphs, the decisional balance groups are going in the wrong direction, compared with the control.

And that, to my knowledge, is the extent of the evidence. I know of no positive clinical trials showing that a decisional balance procedure actually promotes behavior change. Indeed, it is not clear to me why one would expect that it should. There is no clear theoretical rationale for why thoroughly exploring *both* sides of ambivalence should work. Intentionally eliciting counter-change arguments seems contrary to what we know from research on motivational interviewing, on the transtheoretical model of change, and on the theories of reasoned action. Clients are *already* ambivalent, and counterbalanced pros and cons are related to contemplation and inaction, not to behavior change. Equally exploring both sides would logically reinforce ambivalence, which is where they were to begin with. It is *moving away from the cons* that is associated with change, with getting unstuck from ambivalence. In Terri Moyers' work, it is change talk that predicts successful outcomes in three different kinds of psychotherapy, and sustain talk predicts lack of change.

Before moving on, though, I do want to highlight one use of the decisional balance that does seem to me to be appropriate, and that is precisely when you *don't* intend to tip the balance in one particular direction. Clients bring into psychotherapy quite a range of life choices, and often they want help in making them. Should they have children, enter into or stay in a marriage, change jobs or majors, enter the ministry or Peace Corps, or have a face lift? Unless you're Dr. Phil or Dr. Laura, you probably prefer to maintain equipoise on such issues, and rightly so. Who are we to be making these decisions for people, even if they ask us to? When you want to *avoid* inadvertently biasing the choice, that's a good time to thoroughly and equally explore both the pros and the cons.

TOWARD A VOLITIONAL PSYCHOTHERAPY

But let me return to my central focus here, and provide a transitional summary. MI was never meant to be a comprehensive psychotherapy. We developed it to address a specific situation in counseling: namely, when a person wants or needs to make a change, but hasn't done so. In this sense MI is one tool to be applied when this challenge arises within psychotherapy or other consultation.

Research on MI, however, may be shedding some light on more general psychotherapeutic processes, and thus teaching us something broader. It appears that the extent to which a therapist manifests the MI spirit of collaboration, evocation, and autonomy support is linked to successful behavior change, as is the practice of accurate empathy. This is a humanitarian therapeutic style that can be used in the delivery of a wide range of interventions, and it is consistent with what Carl Rogers described as the necessary and sufficient conditions to facilitate change. It is fairly clear, from Truax through radical behaviorism all the way to MI research, that therapists can and do influence what clients are likely to say in psychotherapy. That might not be terribly interesting in itself, except that it also seems to *matter* what clients say. They talk themselves into or out of change.

Yet there is something larger here as well. It seems to be that motivational interviewing points to a broader perspective on human nature and the process of facilitating change, a perspective with

ISSN 2160-584X (online) Vol. 1 No. 1 (2012) DOI 10.5195/mitrip.2012.6

implications for the more general enterprise of psychotherapy. The nature of this perspective is emergent, but I think there are several clear component assumptions, and I want to address these as potential cornerstones of a volitional psychotherapy.

First, I would suggest that MI points to an underlying belief in the profound human capacity and tendency to grow in positive directions. Think about it. MI is not about *docere*, about installing things that the person is lacking. There is no skill training, counterconditioning, analysis of transference, refutation of irrational beliefs, or installation of insight. We're only talking about relatively brief consultation here. Rather MI seeks to elicit that which is already there, already present in the person. That implies a trust in the person's own wisdom, motivation, capacity for change, and right to self-direction. It is the client who brings into the consultation room the expert tools that are needed for change to happen. Our relationship to the client and to the process of change is much like that of a midwife. We don't provide the baby.

Second, MI clearly implies a central role for volition, for choice and decision (Miller & Atencio, 2008). It is not a deterministic view in which our behavior is merely the cross-product of heredity and environment. People regularly stand at forks in the road and make choices. Motivational interviewing is about facilitating healthy choices. We also affirm and support the person's autonomy, the right and ability of self-determination.

Third, MI manifests an acceptance and understanding of ambivalence. Robert Frost's (1969) classic poem *The Road Not Taken* captures the heart of ambivalence, and recounts a choice of path: "Two roads diverged in a yellow wood, and sorry I could not travel both and be one traveler, long I stood..." We understand the dialectic of pros and cons as being *within* the person, not a power struggle between counselor and client.

Fourth, we attend closely to language in MI—both our own and our client's. Language symbolizes the internal process of weighing and making choices. It is not an epiphenomenon, but rather our window into the inner workings of volition, of human will.

All four of those streams are present in the process of motivational interviewing. Could they not also be manifest over a longer course of consultation? Of course they could. Now, to some extent, the very brevity of MI is itself a reflection of these perspectives: that people are already capable of change, choose the course of their behavior, work out the direction of their lives through choices about which they are ambivalent, and can process these choices in language. If we are working with capable, choosing human beings, the process of consultation might be relatively brief.

But the process is not *necessarily* brief. There are many kinds of relationships that endure across time, in which a professional (or for that matter, a friend) serves as a companion across hundreds, thousands, or hundreds of thousands of choices that comprise a span of life and determine its direction. The relationship might be psychotherapy, mentoring, probation, primary health care, coaching, spiritual direction, supervision, pastoral care, or an ongoing support group. These same principles can guide and inform a longer process of companionship that transcends particular issues or life choices.

What might such a relationship look like? If you're not focused on a specific target behavior, as has been the normative situation with motivational interviewing, what are you doing together, and what is your particular role? Here I return to a theme that has been circulating through the MINT world for some time, and that is *values*. If we are indeed capable, choosing, self-determining people who work out the course of our lives through countless decisions small and large, what does it mean to facilitate a *life*, and not just a particular behavior change? To me, it means, at least in part, to help people develop clarity and commitment regarding their own values, the broader goals and principles by which they mean to live their lives, and then to bring their actions, their daily choices, into the service of those ends. A word for that is "integrity," to live with consistency and adherence to one's chosen values.

I am saying something different here from the classic humanistic movement of the 1960s, where a primary goal was often to live *in the moment*, *in the present*. There are certainly good reasons for mindfulness, for being consciously aware of and enjoying this very moment's experience. It is what we share with the animal world. Yet the Buddhist gurus of mindfulness also seek to live their lives in strict accord with central principles, to be in conscious consistency with certain core values. They live a *directed* and disciplined life.

How very easy it is to live just in the present, to focus on short-term gain and pleasure, to fritter away time in ways that do not serve, or that even undermine our own values and purpose. That is pathognomonic of substance dependence. Time managers and religious leaders alike have advocated writing a "mission statement" for one's own life, to remind us of our central goals and purpose. Toward the end of his life and distinguished career as a learning theorist, O. H. Mowrer was developing what he called "integrity therapy," a relational approach for helping people to live in conscious accord with their values (Lander & Nahon, 2005; Mowrer, 1966). He was seeking an antidote to the hazards of modern life, a way to live with purpose. A volitional approach to relationship, one that is broadly based on the same principles as MI, holds real promise in this regard. It can be used to help people align their lives with values and purpose. That purpose might be a wholly unique constellation of the individual's conscious values, or a broader set of precepts such as those of a particular religion to which the person aspires.

And so I come full circle to Carl Rogers, and the concept of self-actualization. It is a very spiritual concept, really, although Rogers himself remained profoundly ambivalent about religion. The core of it is that each person has an inherent nature, an intended end-state toward which he or she naturally develops if given the proper conditions of support. The ancient Greek term for this concept is *telos*, the natural, fully mature and perfected form of an organism. The *telos* of an acorn is the oak tree. The last words of Jesus, during his execution on the cross, are often translated as "It is finished," but the Greek is a form of *telos*: it is complete, it is perfect, I have accomplished what I was meant to do." A volitional perspective on psychotherapy and more generally on relationship would seek to help each person find and develop toward that *telos.* It's a far horizon of motivational interviewing, and one that I believe is well worth pursuing.

REFERENCES

Collins, S. E., & Carey, K. B. (2005). Lack of effect for decisional balance as a brief motivational intervention for at-risk college drinkers. *Addictive Behaviors, 30,* 1425-1430.

Deci, E. L., & Ryan, R. M. (1985). *Intrinsic motivation and self-determination in human behavior.* New York: Plenum Press.

Frost, R. (1969). *The poetry of Robert Frost.* New York: Holt, Rinehart & Winston.

Gollwitzer, P. M. (1999). Implementation intentions: Simple effects of simple plans. *American Psychologist, 54,* 493-503.

Lander, N. R., & Nahon, D. (2005). *The integrity model of existential psychotherapy in working with the "difficult patient."* New York: Routledge.

Mahoney, M. J., & Thoresen, C. E. (1974). *Self-control: Power to the person.* New York: Brooks Cole.

ISSN 2160-584X (online) Vol. 1 No. 1 (2012) DOI 10.5195/mitrip.2012.6

Matzger, H., Kaskutas, L. A., & Weisner, C. (2005). Reasons for drinking less and their relationship to sustained remission from problem drinking. *Addiction, 100,* 1837-1646.

Miller, W. R., & Atencio, D. J. (2008). Free will as a proportion of variance. In J. Baer, J. C. Kaufman, & R. F. Baumeister (Eds.). *Are we free? Psychology and free will* (pp. 275-295). New York: Oxford University Press.

Miller, W. R., & Moyers, T. B. (2006). Eight stages in learning motivational interviewing. *Journal of Teaching in the Addictions, 5,* 3-17.

Mowrer, O. H. (1966). Integrity therapy: A self-help approach. *Psychotherapy: Theory, Research and Practice, 3,* 114-119.

Moyers, T. B., Martin, T., Tonigan, J.S., Christopher, P.J., Houck, J.M. and Amrhein, P. (2007). Client language as a mediator of motivational interviewing efficacy: Where is the evidence? *Alcoholism: Clinical and Experimental Research, 31* (S3), 40S-47S.

Prestwich, A., Lawton, R., & Conner, M. (2003). The use of implementation intentions and the decision balance sheet in promoting exercise behaviour. *Psychology & Health, 18*, 707-721.

Rogers, C. R. (1980). *A way of being.* Boston: Houghton Mifflin.

Thoresen, C. E., & Mahoney, M. J. (1974). *Behavioral self-control.* New York: Holt, Rinehart & Winston.

Truax, C. B. (1966). Reinforcement and non-reinforcement in Rogerian psychotherapy. *Journal of Abnormal Psychology, 71*, 1-9.

ISSN 2160-584X (online) Vol. 1 No. 1 (2012) DOI 10.5195/mitrip.2012.6

Motivational Interviewing
TRAINING · RESEARCH · IMPLEMENTATION · PRACTICE
MITRIP

Guidance for New Motivational Interviewing Trainers When Training Addiction Professionals

Findings from a Survey of Experienced Trainers

Julie A. Schumacher, PhD[1], Scott F. Coffey, PhD[2], Kimberly S. Walitzer, PhD[3], Randy S. Burke, Ph[4], Daniel C. Williams, PhD[4], Grayson Norquist, MD, MSPH[1], T. David Elkin, PhD[2]

Abstract

Evidence-based practices, such as motivational interviewing (MI), are not widely used in community alcohol and drug treatment settings. Successfully broadening the dissemination of MI will require numerous trainers and supervisors who are equipped to manage common barriers to technology transfer. The aims of the our survey of 36 MI trainers were: 1) to gather opinions about the optimal format, duration, and content for beginning level addiction-focused MI training conducted by novice trainers and 2) to identify the challenges most likely to be encountered during provision of beginning-level MI training and supervision, as well as the most highly recommended strategies for managing those challenges in addiction treatment sites. It is hoped that the findings of this survey will help beginning trainers equip themselves for successful training experiences.

Keywords

motivational interviewing, workshop training, clinical supervision

Motivational Interviewing (MI; Miller & Rollnick, 2002), a treatment method originally developed for alcohol problems (Miller, 1983), has since been successfully adapted to treat other substance use problems (see Lundahl, Kunz, Brownell, Tollefson, & Burke, 2010 for review). Additionally, in a large effectiveness trial conducted as part of the National Institute on Drug Abuse Clinical Trials Network, MI was shown in "real world" substance abuse treatment settings to reduce treatment attrition when incorporated into the assessment process (Carroll et al., 2006). Nonetheless, despite its origins as a treatment for substance use problems, a large and increasing body of research supporting its efficacy for this purpose, publication of the first MI text almost two decades ago (Miller & Rollnick, 1991), and evidence from an effectiveness trial that it is possible to successfully implement practices such as MI in "real world" settings, MI (like other evidence-based treatments for substance use problems) is not widely used in these settings (Miller, Sorensen, Selzer, & Brigham, 2006; Morgenstern, 2000). Too often, alcohol and drug treatment providers rely on treatments supported only by anecdotal and idiographic evidence (Carroll & Rounsaville, 2003), treatments with a demonstrated lack of efficacy (Miller et al., 2006), or treatments based only loosely on evidence-based practices (Hanson & Gutheil, 2004). With regard to loose adoption of evidence-based practices: although some might argue that any adoption of evidence-based practices is better than no adoption of such practices, clear evidence to support such assertions is generally lacking. Level of therapist competence and adherence to evidence-based practices has been positively associated with treatment outcomes across many disorders and therapeutic approaches (e.g., McIntosh et al., 2005; Shaw et al., 1999). Thus, a loose adoption of evidence-based practices is unlikely to yield treatment outcomes comparable to those achieved in research.

The limited success of efforts to implement evidence based practices in community alcohol and drug treatment programs stems from many causes. One cause, certainly, is insufficient training opportunities. As Calhoun, Moras, Pilkonis, and Rehm (1998) note, the level of training provided at continuing education workshops is typically insufficient to achieve meaningful changes in provider behavior. In a review of the effectiveness of workshop training for psychosocial addiction treatments, Walters, Matson, Baer, and Ziedonis (2005) concluded that workshops reliably improve providers' confidence, attitudes, and knowledge. However, skill improvements are not often measured. Furthermore, when skill improvements are assessed, they are often apparent immediately following the workshop, but not maintained over time.

Research specifically focused on training in MI has confirmed that workshop training alone may increase skill, but is insufficient for most providers to achieve competence in MI (Miller & Mount, 2001). Moreover, although incorporating systematic feedback on performance has been shown to improve task performance (Locke & Latham, 1990), small amounts of feedback following workshop training are also insufficient for most providers to achieve competence in MI (Miller, Yahne, Moyers, Martinez & Pirritano, 2004). More recent studies have shown that even multiple supervision or coaching sessions may be insufficient for this

[1]University of Mississippi Medical Center and G.V. (Sonny) Montgomery VAMC [2]University of Mississippi Medical Center [3]Research Institute on Addictions, University at Buffalo, State University of New York [4]G.V. (Sonny) Montgomery VAMC and University of Mississippi Medical Center

The project described was supported by Grant Number R25DA026637 from NIDA. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of the NIH. The authors have no commercial interests that would bias the objectivity of the work presented.

Correspondence concerning this article should be addressed to: Julie A. Schumacher, Ph.D., Department of Psychiatry and Human Behavior University of Mississippi Medical Center, 2500 North State Street, Jackson, MS 39216, Email: jschumacher@umc.edu

ISSN 2160-584X (online) Vol. 1 No. 1 (2012) DOI 10.5195/mitrip.2012.7

purpose (Smith et al., 2007; Mitcheson, Kaanan & McCambridge, 2009). However, in these studies, MI trainees were offered a pre-determined number of supervision or coaching sessions; feedback-based supervision or coaching that continues until the trainee achieves competence is likely a necessary follow-up to workshop training in order to have successful knowledge and skill transfer. This is problematic given that few facilities are equipped to provide this type of training and clinical supervision (Martino et al., 2006).

Even when sufficient training is made available to providers, technology transfer may fail for a variety of reasons such as: lack of incentives for adopting new practices, lack of knowledge or support for new practices by administrators, unwillingness of administrators to modify existing practices to ensure the success of new practices, strong voices of opposition to new practices or support for existing practices, and lack of opportunities for staff input into adoption of new practices (Addiction Technology Transfer Center, 2004). Thus, successful dissemination of MI to "real world" settings will require not only training a large number of MI trainers and supervisors in order to meet the need for intensive and ongoing feedback-based training, but it also requires adequately preparing these trainers and supervisors to manage a variety of barriers to successful technology transfer.

The current survey was conducted to gather opinions and advice from experienced MI trainers, both within and outside the Motivational Interviewing Network of Trainers, to inform a curriculum designed to prepare individuals who are, themselves, proficient in MI to have successful first experiences in providing training and supervision in MI to addiction treatment providers. Specifically, the first aim of the current survey was to obtain expert opinions about the optimal format, duration, and content for beginning level MI training conducted by novice trainers. The second aim of the current survey was to identify the challenges most likely to be encountered during provision of beginning MI training and supervision, as well as the most highly recommended strategies for managing those challenges. The findings of this survey are intended to help beginning trainers make better use of high quality, publicly available training and technology transfer materials, including the *Motivational Interviewing Assessment: Supervisory Tools for Enhancing Proficiency* (Martino et al., 2006), the *Motivational Interviewing Training for New Trainers (TNT) Resources for Trainers* (MINT, 2008), and the *Change Book* (ATTC, 2004).

METHOD

Participants

Recruitment of respondents employed three strategies intended to help us obtain a diverse sample of individuals with experience in training MI. First, two emails were posted to the Motivational Interviewing Network of Trainers (MINT) listserv describing the curriculum development project and directing interested participants to the web-based survey. Second, the survey team used using the keyword "motivational interview" to search the National Institutes of Health CRISP database to identify individuals currently conducting MI research. Emails were sent to the identified researchers describing the project and inviting them to participate in the web-based survey. Finally, two emails were posted to the Association for Behavioral and Cognitive Therapies (ABCT) listserv describing the project and directing interested participants to the survey. Although respondents were not asked to indicate the survey invitation that brought them into the survey, the large proportion of respondents who identified themselves as MINT members (81%), suggests emails to the MINT listserv may have yielded the greatest number of respondents.

A total of 36 individuals responded to the survey. Thirteen respondents were male and 23 were female. Twenty-three respondents reported their age was between 35 and 54 years of age. The remaining respondents reported their age as between 55 and 74 (n = 7) or 25-34 (n = 6). Thirty-three respondents identified their race as White, and thirty-one reported their ethnicity as "Not Hispanic or Latino." One respondent did not provide race information and 3 respondents did not provide ethnicity information.

Thirty respondents lived in the United States with the remaining 6 respondents indicating they lived in Austria, United Kingdom, Canada, or Italy. Twenty-four respondents reported that their highest educational attainment relevant to the practice and training of MI was a doctorate in a mental health related field, 8 reported that they had a Master's in a mental health related field (n = 5) or field unrelated to mental health, nursing, or criminal justice (n = 3). The remaining 4 respondents reported 4-year degrees in nursing (n = 1), a criminal justice related field (n = 1), or a field unrelated to mental health, nursing, or criminal justice (n = 2).

Twenty-nine respondents were members of the Motivational Interviewing Network of Trainers. Among these, 10 had been members for 1-2 years, 10 had been members for 3-5 years, and 9 had been members for 6 or more years.

All but one respondent (n = 35) reported some experience in providing training in MI, the remaining respondent skipped items pertaining to training experience. Training ranged from very brief presentations to 3+ day workshops or quarter/semester length courses. There was substantial variability in the amount of training provided. Thirty-three respondents had provided some individual or group supervision in MI. Among those who had provided training, estimates of the number of individuals to whom training had been provided ranged from 3 to 1005 (median = 372.5), with 30 respondents reporting they had provided training to 100 or more different individuals. There was also a large amount of variance in the amount of supervision experience reported. Of those who had provided supervision, estimates of the number of individuals to whom supervision had been provided ranged from 3 to 955 (median = 51), with 26 reporting they had supervised more than 10 individuals.

Measures

All data were collected using a survey instrument developed for this curriculum development project. The survey was divided into three sections: 1) background; 2) training format, duration, and content; and 3) effectively managing challenges during MI training. The survey instrument was developed by the authors of this paper with content informed by ongoing dialogues on the Motivational Interviewing Network of Trainers listserv about issues that arise during the provision of MI training.

Background

The instrument began with items assessing respondent demographic background as well education and experience relevant to MI training and supervision.

Training format, duration, and content

The next section of the survey asked for respondent opinions about 1) optimal trainer to trainee ratios for beginning MI training (ranging from 1:3 or less to greater than 1:18), 2) the maximum number of trainees for beginning MI training (ranging from 5 or fewer to 36-40), 3) the perceived benefits of supervision that includes feedback on taped samples to achievement of proficiency and competence (ranging from 1 = very beneficial to 5 = very unbeneficial), and 4) the willingness of typical trainees to provide tapes samples of their work (ranging from 1 = very willing to 5 = very unwilling).

Following these items, respondents were asked to select the 10 exercises from a prior version of *MI Training for New Trainers Resources*

ISSN 2160-584X (online) Vol. 1 No. 1 (2012) DOI 10.5195/mitrip.2012.7

for Trainers (MINT, 2003) that they most highly recommended for beginning trainers conducting their first MI training. The audience for the training was specified as addiction treatment providers with varied levels of formal training. Respondents were instructed to select exercises based on how easy they believed the exercise would be for a beginning trainer to implement and how effective they felt it was. Thus, respondents were *not* asked for their opinions about best practices and content for MI training in general, but rather about those practices that would be most likely to result in a successful first workshop experience for a beginning trainer. The original 23 training exercises are listed and briefly described in Table 1.

Table 1

Number of respondents endorsing each training exercise as being in the 10-best for beginning

Exercise	*Description*	*N (%)*
Batting Practice	Participants "pitch" a series of statements to a batter, who attempts to reflect each statement	24 (69%)
Negative Practice	Listeners use persuasion or roadblocks with a speaker discussing a change they are considering	23 (66%)
Observer Tracking: OARS	Participants track therapist use of open questions, affirmations, reflections, and summaries during an observed interaction	23 (66%)
Round Robin	Participants practice skills in a group by taking turns responding to a "client"	20 (57%)
Readiness Ruler Line-up	Participants use readiness ruler to examine their own readiness for training activities	20 (57%)
Structured Practice with a Coach	Listener and speaker are given well-defined roles, usually with carefully specified communication rules; listener gets coaching as needed from another participant	18 (51%)
Observer Tracking: Reflections	Participants track therapist use of reflections during an observed interaction	17 (49%)
Dodge Ball	Like batting practice, but anyone in the group can provide a stimulus or response	16 (46%)
Structured Practice	Listener and speaker are given roles, usually with carefully specified communication rules	15 (43%)
Team Consult	Advisory team provides the listener guidance on what to do during the structured practice	14 (40%)
Observer Tracking: Change Talk	Participants track client utterances about desire, ability, reasons, need, or commitment for change during an observed interaction	14 (40%)
Tag Team	Several participants serve as listener, so as one gets stuck she can tag the next into the exercise	13 (37%)
Brainstorming	Trainer poses a topic, for example, "What is resistance," and group generates ideas/responses	12 (34%)
Observer Tracking: Client Readiness	Participants track client readiness to change a target behavior during an observed interaction	11 (31%)
Sentence Stems	Trainer provides sentence stems, participants write responses and volunteer to share with group	10 (29%)
Virginia Reel	Form two lines of 4 or more trainees facing each other - counselors have the opportunity to talk sequentially to different clients in order to practice specific counseling skills	8 (23%)
Protagonists	One speaker discusses an issue about which he or she is ambivalent and 4 different listeners take turns with different approaches to resolving the ambivalence	7 (20%)
Three in a Row	Participants describe a typical client, and trainer reports that they are scheduled to see three of these clients in a row to discuss behavior change; the group discusses helpful techniques	7 (20%)
Unfolding Didactic	Presenting didactic material in a way that draws the audience through progressive clues	6 (17%)
Observer Tracking: Wrestling/Dancing	Participants track client/counselor interaction using a continuum from "wrestling" (struggling with one another for control) to "dancing" (moving together smoothly and cooperatively)	5 (14%)
Solitary Writing	Structured writing assignments to be completed independently in prescribed time period	5 (14%)
Quizzes	Self-test to assess participants' understanding of concepts, such as open versus closed questions	4 (11%)
Observer Tracking: Counselor Client Process	Participants track every counselor and client utterance into one of a small number of categories during an observed interaction	2 (6%)

Note. n = 35.

ISSN 2160-584X (online) Vol. 1 No. 1 (2012) DOI 10.5195/mitrip.2012.7

The final items in this section asked respondents to rate the importance (using a scale that ranged from 1 = very important to 5 = very unimportant) to first time MI trainers of 14 general principles/approaches listed in the 2003 resources book. These principles/approaches are presented in Table 2. Complete descriptions of all of these exercises and principles, with the exception of "observer tracking: counselor-client process" are available in the most recent version of the resources book (MINT, 2008).

Table 2

Perceived importance for beginning MI trainers of general principles/approaches to MI training

Principle/Approach	*Description (if applicable)*	*Importance Rating Mean (SD)*
Trainer demonstrations		1.36 (0.60)
Role-plays		1.36 (0.70)
Eliciting	Asking for trainee input throughout training	1.37 (0.69)
Debriefing each activity		1.49 (1.01)
Setting up a successful role play	Give clear instructions before starting	1.57 (0.95)
Giving feedback to trainees	Suggestions or observations during exercises	1.63 (0.88)
Vital Signs	Ask group about training desires, etc.	1.71 (0.75)
Structuring	Giving trainees an overview of training	1.74 (0.79)
Video demonstrations		1.74 (1.02)
Generalizing gains	Giving guidance on how to increase expertise in MI	1.86 (0.91)
Preparing a client role	Provide prepared client biography for role play	2.03 (0.77)
Personalizing	Asking trainees to use personal info. during training	2.14 (1.24)
Using metaphor or nonverbal imagery	E.g., "change bouquet"	2.21 (0.89)
Structured counselor feedback	Observe and code trainee performance	2.55 (1.00)
Pre-training structured assessment		2.85 (1.02)

Note. n = 35. Means are based on the following scale: 1 = very important; 2 = somewhat important; 3 = neither important nor unimportant; 4 = somewhat unimportant; 5 = very important

Effectively managing challenges encountered during MI training and supervision

The final section of the survey asked respondents to indicate how often they encountered various challenges during MI training and supervision, as well as what they believed to be the best approach to handling each challenge. Respondents indicated how frequently they encountered each challenge using a 5-point scale (ranging from 1 = never to 5 = always). Response options for how to handle each challenge varied for each type of challenge. The first seven items queried respondents about the frequency with which various participant utterances were encountered during training (see Table 3). These items began with the stem, "One or more participant expresses the belief that…" Sample items include: "MI is just good counseling or 'common sense'" and "patients must embrace a particular label in order to recover." Respondents were then asked to indicate which of the following methods they most recommended for addressing each statement: a) reflection (i.e., using reflective listening); b) shifting focus (i.e., address the concern and move to a more workable issue); c) reframing or agreement with a twist (i.e., reflect or validate the trainee's observations, but offer a new meaning or interpretation for them); d) information provision (providing information or data to address the trainee's concern); e) emphasizing control (i.e., reminding trainees that they will have to decide whether MI is an approach they want to use); and f) other. All response options except information provision and other were selected from the menu of options recommended in MI for rolling with resistance (Miller & Rollnick, 2002).

As shown in Table 3, the next seven items assessed how frequently respondents had encountered challenging participant behaviors. These items began with the stem, "One or more participants…" Sample items include: "will not engage in practice exercises" and "express or evidence anxiety during practice exercises." Respondents were then asked to indicate which of the following methods they most recommended for addressing each behavior: a) silently observe the participant(s)' practice group; b) observe the participant(s)' practice group and "jump in" with coaching/suggestions; c) observe the participant(s)' practice group and selectively praise behavior; d) actively join the participant(s)' ongoing practice group; e) ask the participant(s) to partner with you on the next practice exercise; f) discuss it with the participant(s) in a serious fashion; g) discuss it with the participant(s) using levity; h) discuss it in a general, but serious fashion with the full group; i) discuss it generally and with levity with the full group; j) other.

ISSN 2160-584X (online) Vol. 1 No. 1 (2012) DOI 10.5195/mitrip.2012.7

Table 3.

Mean frequency with which trainee-related challenges are encountered in workshop training

Challenge encountered	*Frequency Mean (SD)*
One or more participants express the belief that…	
MI is just good counseling or "common sense."	3.21 (1.07)
they already do MI (and you doubt this is accurate)	3.53 (1.08)
MI takes too much time and is impossible to implement in their setting(s)	3.15 (1.18)
confrontation is an essential part of treatment	2.41 (0.96)
reflections are presumptuous or will elicit resistance	2.53 (1.05)
patients cannot possibly recover without ___ (a particular form or duration of treatment)	2.21 (0.88)
patients must embrace a particular label in order to recover (e.g., Alcoholic, SMI, etc.)	2.03 (0.94)
One or more participants…	
express or evidence anxiety when the trainer observes them during practice exercises	3.41 (0.99)
express or evidence anxiety during practice exercises	3.15 (1.08)
have noticeably less developed basic counseling skills than the other participants	3.09 (1.00)
repeatedly disengage from practice exercises to chat	2.38 (0.78)
will not engage in practice exercise	1.97 (0.47)
inappropriately disclose too much personal information during a practice exercise	1.85 (0.78)
use role plays to complain about their supervisors or others in the room	1.76 (0.70)

Note. n = 34. Means are based on the following frequency scale: 1 = never, 2 = seldom, 3 = about half the time, 4 = usually, 5 = always

The next three items pertained to challenges encountered during MI supervision or coaching, including challenges related to the provision of work samples. As such, only respondents who indicated they currently supervised or coached and asked supervisees to provide taped work samples answered these items. Respondents were asked how frequently one or more supervisees or mentees: 1) "forget" supervision/coaching sessions; 2) will not provide tapes for supervision/coaching; and 3) believe that their taped sample was very proficient while the actual feedback indicated that it was largely MI-inconsistent (i.e., confrontational, many closed questions, not evocative or directive). Respondents were then asked which of the following strategies they most recommended for managing each challenge: a) discuss it with the participant(s) in a serious fashion; b) discuss it with the participant(s) using levity; c) discuss it in a general, but serious fashion with the full group; d) discuss it generally and with levity with the full group; e) other.

The final five items referred to agency-level challenges encountered by respondents when providing MI training. These items were only answered by respondents who indicated they had interacted with agencies when providing MI training. Respondents were first asked to indicate how often they had encountered each of the following challenges using a 5-point scale (ranging from 1 = never to 5 = always): 1) agency does not release participants from their duties for the full duration of training; 2) agency forces staff to participate against their will; 3) agency requires participants to respond to their pager or cell phone during training; 4) agency requests a shorter than necessary training; 5) agency requests training, but refuses to modify their procedures in a way that will allow for successful MI incorporation. Respondents were then asked which of the following strategies they most recommended to address the challenge: a) continue with training as planned; b) provide data/information; c) negotiate a compromise; d) refuse to conduct or complete the training; e) other.

Procedure

All survey responses were collected anonymously via an online survey research tool. The survey was designated by the University of Mississippi Medical Center Institutional Review Board as exempt human subjects research.

RESULTS

Training Exercises

There was substantial variability in respondent perspectives about the best training exercises for beginning trainers. As shown in Table 1, all practice exercises listed were placed in the top 10 by at least 2 respondents, and the highest rated exercise was endorsed by only 69% of respondents. Six exercises were selected by at least ½ the sample *(n* = 18*)*: batting practice (*n* = 24), negative practice (*n* = 23), observer tracking- OARS (*n* = 23), round robin (*n* = 20), readiness ruler line-up (*n* = 20), and structured practice with a coach (*n* = 18). The remaining exercises among the 11 most highly ranked were observer tracking – reflections (*n* = 17), dodge ball (*n* = 16), structured practice (*n* = 15), team consult (*n* = 14), and observer tracking – change talk (*n* = 14). The five exercises with the lowest ranking were unfolding didactic (*n* = 6),

ISSN 2160-584X (online) Vol. 1 No. 1 (2012) DOI 10.5195/mitrip.2012.7

observer tracking – wrestling or dancing (*n* = 5), solitary writing (*n* = 5), quizzes (*n* = 4), and observer tracking – counselor client process (*n* = 2).

Principles of Training

As shown in Table 2, 10 out of 15 principles or general approaches were rated on average between 2 = fairly important to 1= very important: role plays, trainer demonstration, eliciting, debriefing each activity, setting up a successful role play, giving feedback to trainees, vital signs, video demonstration, structuring, and generalizing gains. The remaining 5 principles or general approaches were rated on average between 3 = neutral to 2 = fairly important: preparing a client role, personalizing, using metaphor and nonverbal imagery, structured counselor feedback, pre-training skill assessment.

Training Logistics

Thirty-four respondents answered the questions about optimal trainer to trainee ratios and maximum training size. There was considerable variance in opinion: 1:10 to 1:12 was the modal rating (*n* = 14); 11 thought a smaller ratio was optimal (1:4 to 1:9) and 9 thought a higher trainer to trainee ratio was optimal (1:13 to 1:18 or higher). Optimal trainer to trainee ratio was significantly correlated with the total number of individuals a respondent had trained (*r* = .51, *p* =.002). There was also considerable variability in perceptions about the maximum size for beginning training. The majority of respondents (*n* = 26) indicated that the optimal training size was between 11 and 25 participants. Only 2 indicated that 10 or fewer participants was optimal and the remaining 6 reported that optimal training size was larger than 25 participants. Maximum number of trainees was not significantly correlated with the total number of individuals a respondent had trained (*r* = .16, *p* = .367).

Challenges Encountered

Respondent utterances during training

A total of 34 respondents provided responses to 7 items inquiring about respondent utterances during training that indicated barriers to training. As shown in Table 3, the most commonly encountered utterances, each of which arose on average about half the time or more, were: “they already do MI,” “MI is just good counseling or common sense,” and “MI takes too much time and is impossible to implement in their setting.” As shown in Figure 2, the most commonly recommended strategies for managing the statement “MI is just good counseling or common sense” were reflection (*n* =14) and reframing (*n* = 16). The most commonly recommended strategies for managing the statement “they already do MI” were also reflection (*n* = 10) or reframing (*n* = 19). Respondents were more varied in their advice on how to manage the statement “MI takes too much time and is impossible to implement in their setting”: 13 recommended reflection, 8 recommended emphasizing control, 5 recommended reframing, and the remaining respondents recommended information provision (*n* = 3), shifting focus (*n* = 2), or other (*n* = 2).

Respondent behaviors during training

A total of 34 respondents provided responses to 7 items about respondent behaviors during training that indicated barriers to training. The most commonly encountered behaviors, each of which was encountered on average about half the time or more were: expressing or evidencing anxiety when trainer observes, expressing or evidencing anxiety during practice exercises, and having noticeably less developed basic counseling skills than other trainees (see Table 3). Twenty-nine respondents provided recommendations about the best approach to managing each of these barriers. As shown in Figure 2, the most commonly recommended strategies to manage trainee anxiety when being observed were: observe and selectively praise (*n* = 8), discuss with trainee using levity (*n* = 8), other (*n* = 5) and observe and “jump in” (*n* = 4). The most commonly recommended strategies to manage anxiety during practice exercises were similar: observe and selectively praise (*n* = 9), discuss with trainee using levity (*n* = 4), observe, “jump in” (*n* = 4), and other (*n* = 4).

Respondent resistance to supervision

All 36 respondents answered questions about how beneficial supervision that included feedback on taped samples was to gaining skill in MI as well as how willing typical trainees are to provide such tapes. Twenty-three respondents indicated that supervision, which included feedback on taped samples was very beneficial, and 9 reported it was beneficial to the achievement of beginning proficiency in MI. Similarly, the majority of respondents indicated that such supervision was very beneficial (*n* = 26) or fairly beneficial (*n* =7) to the achievement of competence in MI. However, only 9 believed trainees would be very willing (*n* = 3) or fairly willing (*n* = 6) to provide taped samples of their work in order to receive supervision. In contrast, 21 indicated that typical trainees are fairly unwilling to provide such samples, and 2 indicated that they are very unwilling.

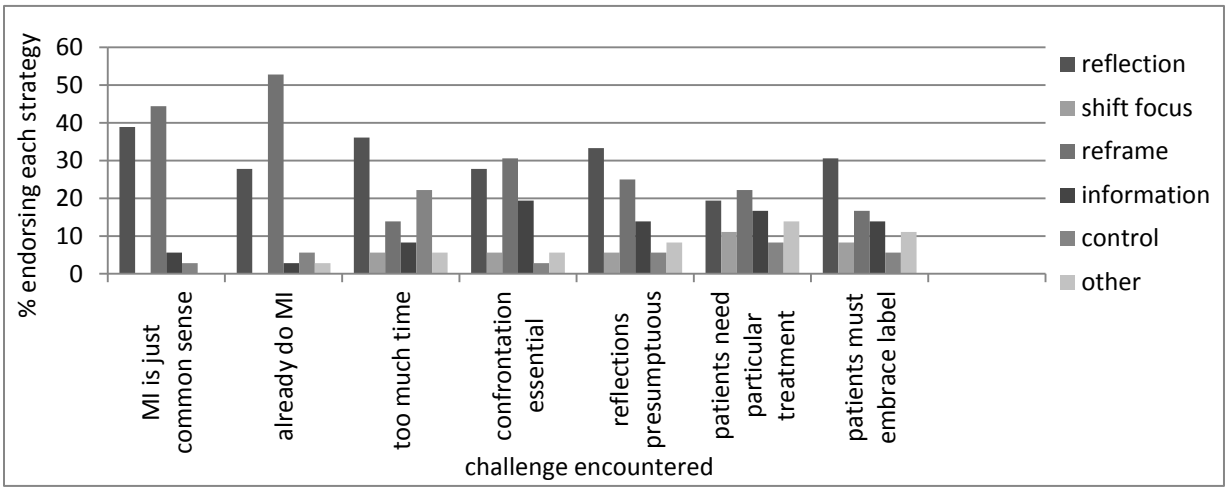

Figure 1

Recommended responses to challenging trainee utterances encountered in workshop training. Thirty-three respondents provided recommendations to address each of the utterances listed, with the exception of “patients must embrace a particular label in order to recover” for which 31 respondents provided recommendations.

ISSN 2160-584X (online) Vol. 1 No. 1 (2012) DOI 10.5195/mitrip.2012.7

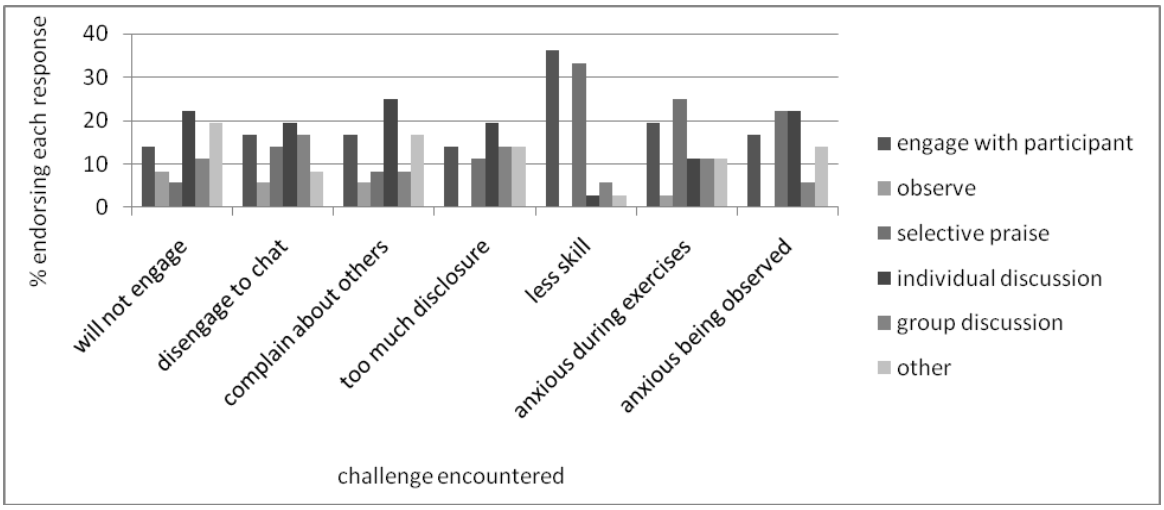

Figure 2

Recommended responses to challenging trainee behaviors most frequently encountered in workshop training. Twenty-nine respondents provided recommendations to address each of the behaviors listed, with the exception of "inappropriately disclose too much information" for which 26 respondents provided recommendations. Observe = silently observe the participant(s)' practice group, selective praise = observe the participant(s)' practice group and selectively praise behavior. For the purposes of simplified presentation, the following recommended trainer responses were collapsed as follows: engage with participant = observe the participant(s)' practice group and "jump in" with coaching/suggestions + actively join the participant(s)' ongoing practice group + ask the participant(s) to partner with you on the next practice exercise; individual discussion = discuss it with the participant(s) in a serious fashion + discuss it with participant(s) using levity; and group discussion = discuss it in a general, but serious fashion with the full group + discuss it generally and with levity with the full group. Complete results are available from the first-author upon request.

Although 33 respondents reported some experience providing supervision, only 23 indicated that they currently provide supervision. Of those, 17 indicated that they require supervisees to submit taped work samples and a total of 19 respondents answered questions about trainee resistance to supervision. These respondents indicated that on average trainees seldom to never forget to provide session tapes (M = 1.84; SD = 0.69), and seldom to about half the time believe a sample was proficient when it wasn't (M = 2.17; SD = 0.62) or will not provide tapes (M = 2.50; SD = 0.86). Discussing each of these issues one-on-one with supervisees in a serious fashion was most commonly selected as the best way to address these potential barriers to training

Agency-related barriers to training

A total of 26 respondents reported that they had provided a training for which the agency sponsoring the training required attendance for its staff, 8 reported that they had not provided such training, 1 reported that he or she did not know and 1 skipped all items in this section. When asked how many currently provided training for agencies, 24 reported yes and 11 reported no. All 24 of the individuals who had provided agency-sponsored training responded to items about agency-related barriers to training. The most commonly encountered barrier to training in this context was agencies forcing staff to participate in training against their will. This was reported to occur on average about half the time or more (M = 3.12, SD = 0.85). Most respondents recommended managing this barrier by continuing with the training as planned (n = 9), other (n = 7), or providing information (n = 6).

An additional three barriers were reported as occurring slightly less than half the time: agency requests shorter than necessary training (M = 2.78, SD = 1.20), requests training, but won't modify agency procedures to allow incorporation of MI in the setting (M = 2.67, SD = 1.20), and agency requires respondents to respond to cell phone or pages during the training (M = 2.63, SD = 1.01). The most commonly recommended strategy for managing requests for insufficient training duration was: negotiating a compromise (n = 12), providing information (n = 5), or continuing with the training as planned (n = 5). The most commonly recommended strategies for agencies unwilling to modify procedures to allow successful adoption of MI were: providing information (n = 10) and negotiating a compromise (n =8). Finally, the most commonly recommended strategies for addressing agencies that require trainees to be "on call" during training were: continuing with the training as planned (n = 10) and negotiating a compromise (n = 8).

DISCUSSION

The goal of the current survey was to glean opinions and advice from experienced MI trainers both within and outside the Motivational Interviewing Network of Trainers to inform a curriculum designed to prepare individuals who are, themselves, proficient in MI to have successful first experiences in providing training and supervision in MI. Respondents to the survey varied greatly in the amount of training they had provided. Thus, the findings represent a mix of perspectives ranging from seasoned trainers sharing the wisdom and refined training approach acquired through years of experience to new trainers sharing still-fresh "lessons learned the hard-way" from their own beginning training experiences.

There was substantial variability in opinions about which exercises are best for beginning trainers conducting a beginning-level workshop. All of the exercises included in the MINT (2003) *Resources for Trainers* were endorsed by at least two respondents as being among the best 10. This may suggest that respondents found the "top ten" response format difficult; perhaps all exercises were viewed as strong, and it was difficult to pick only 10. Overall responses indicated that a variety of types of exercises were viewed as best for novice trainers. For example both exercises requiring trainees to generate isolated MI consistent responses (e.g., batting practice, dodge ball, round robin, team consult) and those requiring participants to generate sustained MI consistent responses (e.g., structured practice, structured practice with a coach) were among the 10 most highly endorsed.

ISSN 2160-584X (online) Vol. 1 No. 1 (2012) DOI 10.5195/mitrip.2012.7

Three of the "observer tracking" exercises were also among the 10 most highly endorsed exercises, indicating that respondents believe directing trainees to carefully observe the process that unfolds during therapeutic interactions is an easily implemented and highly effective training tool. Interestingly, each of these three most frequently endorsed observer tracking exercises involved tracking objective behaviors by either the therapists (OARS, reflections) or the clients (change talk). Although respondents were not asked to provide reasons for their selections, these targets for tracking may be viewed as easier to explain to trainees or as more clearly demonstrating to trainees the target behaviors of MI. The finding that the "counselor-client process" and "wrestling or dancing" observer tracking exercises were among the 5 least endorsed exercises is fairly consistent with those interpretations; these two tracking exercises require to trainees to infer and rate therapeutic process variables and thus might require greater trainer skill to present and debrief in a way that optimizes learning of MI.

Finally, negative practice and readiness ruler line-up were also among the 10 most highly endorsed. Negative practice, which requires trainees to use MI-inconsistent responses, was the second most-frequently endorsed exercise, suggesting respondents believe it is beneficial for trainees to contrast use of MI consistent responses to other counseling responses. The readiness ruler line-up, which is an experiential demonstration of this MI technique, was the fifth most endorsed. This may suggest that respondents believe this is an optimal way for beginning trainers to teach this technique for eliciting change talk, and/or that explicit modeling of various aspects of MI spirit through exploration of trainees' ambivalence about learning or using MI may enhance a beginning trainer's ability to convey the spirit of MI. Interestingly, three of the exercises that might be considered the least interactive or the most like traditional education techniques--"unfolding didactic," "quizzes," and "solitary writing"—were among the five exercises with lowest endorsement.

There was considerable response variability among respondents regarding the optimal trainer to trainee ratio and the optimal size of the training group. An interesting finding from this survey was that optimal trainer to trainee ratio was significantly correlated with the total number of individuals a respondent had trained. This may suggest that more seasoned trainers were more comfortable with larger groups, either due to greater MI training self-efficacy gained through years of training or positive experiences training large groups. On the other hand, this association may simply suggest that trainers who perceive larger trainings as more beneficial tend to conduct larger trainings, and thus reported a greater number of trainees.

With regard to general principles of, and approaches to, MI training, 10 principles or approaches had a mean rating in the "somewhat important" to "very important" range and the remaining five had a mean rating in the "neither important nor unimportant" to "somewhat important range." In general, those in the latter grouping were more specific (e.g., "preparing a client role") than those in the former (e.g., "role plays). This suggests that on average respondents believe there is considerable room for latitude in how training is implemented, but that inclusion of demonstrations, role plays, explicit instructions, overviews and debriefings, trainee input, as well as guidance to trainees about their performance during the training and how to improve their performance following the training lead to more successful beginning training experiences.

Structured counselor feedback (based on observed and coded trainee performance) had the second to the lowest mean ranking. This is interesting given that 26 respondents indicated that such feedback is very beneficial for trainees to achieve competence, whereas only 3 of respondents believed that trainees would be very willing to provide work samples to obtain such feedback. Observing and coding trainee practice *during a workshop* or recording such practices for later coding may help trainers and trainees overcome this barrier to training. The authors have adopted this practice in the ongoing curriculum development project and anecdotally have found that although trainees express some reluctance, they are willing to allow the practice to be recorded. Moreover, it seems to promote provision of additional work samples during the coaching offered after the workshop.

Respondents offered numerous recommendations for managing trainee resistance. Across a variety of trainee utterances that might present a challenge to beginning trainers, reflection and reframing were among the most highly recommended strategies. The most commonly encountered behavioral challenges related to anxiety of trainees with varying levels of pre-training skill. Selective praise was highly endorsed as a strategy for managing all of these challenges. Serious one-on-one discussions were the most frequently recommended strategy to manage challenges encountered during supervision/coaching. With regard to agency-related barriers, each barrier was fairly unique in its most frequently endorsed strategy.

The above results suggest that beginning trainers may need to be more specific in their responses to agency-related barriers to increase the likelihood of successful training experiences. The most commonly endorsed strategies overall—negotiate a compromise, give information, and continue with the training as planned—suggests that beginning trainers should enter their first trainings equipped with sufficient knowledge of the literature on MI and technology transfer to justify their approach to training, strong negotiation skills, and a willingness to continue with training under less than optimal circumstances.

Limitations

An important limitation of the current study was the low response rate. The respondents to the survey were a highly self-selected sample of MI trainers. Although the collective amount of training provided by this group of respondents' increases confidence that these survey findings can be considered an "expert" opinion on MI training and supervision, the findings likely do not reflect the "consensus" opinion of the broader MI training community. Also, the survey focused on hypothetical training provided within an addiction setting so it is not known if the findings from this survey would generalize to other training settings.

Additional limitations of the current study include that the questions were quantitative, forced-choice response options and that the questions did not specifically focus on respondent's experiences training addiction treatment providers, although the hypothetical training group was described as addiction treatment providers. A free-response format would have provided a greater window into the wisdom and insights of each of the respondents and questions probing addiction-specific training may have produced different responses. Readers are encouraged to use the findings of this survey with other published information about MI training specifically (e.g., Madson, Loignon, & Lane, 2009) and technology transfer more broadly (e.g., ATTC, 2004) and to seek out mentoring in MI training from an experienced trainer.

Conclusions and Future Directions

In drawing conclusions from these findings, it is important to keep in mind that respondents were *not* asked for their opinions about best practices and content for MI training in general. Rather, they were asked specifically to identify exercises and principles from a specified set of long-standing exercises and principles (MINT, 2003) that would most likely result in a successful first workshop experience for a beginning trainer. Based on responses, the authors conclude that a mix of negative practice, experiential exercises (e.g., readiness ruler line-up), very structured observations of counselor and client behavior (i.e., observer

ISSN 2160-584X (online) Vol. 1 No. 1 (2012) DOI 10.5195/mitrip.2012.7

tracking), targeted skill development activities (e.g., batting practice), and opportunities for extended practice of MI skills (e.g., structured practice) is likely to result in a manageable and successful first training experience. Clear instructions, ongoing feedback to trainees, demonstrations, role-plays, trainer interest in and responsiveness to trainee needs and desires, as well as some discussion of ongoing trainee development can also be essential to successful first training experiences.

With regard to challenges encountered during training, it appears that: a) various challenges are frequently encountered during workshops and supervision/coaching; b) these challenges occur at both the individual trainee and agency level; and c) a broad variety of strategies are identified as useful by respondents for managing these challenges. Prior to their first training experience, beginning trainers may find it useful to rehearse and role play recommended strategies for managing the most frequently encountered challenges. If not successfully managed, these challenges may undermine the training experience for both the beginning trainer and the group of trainees he or she seeks to train.

REFERENCES

Addiction Technology Transfer Center (2004). *The Change Book.* ATTC, Kansas City, MO.

Calhoun, K.S., Moras, K., Pilkonis, P.A., & Rehm, L.P. (1998). Empirically supported treatments: Implications for training. *Journal of Consulting and Clinical Psychology, 66,* 151-162.

Carroll, K.M., Ball, S.A., Nich, C., Martino, S., Frankforder, T.L., Farentinos, C., Kunkel, L.E., Mikulich-Gilbertson, S.K., Morgenstern, J., Obert, J.L., Polcin, D., Snead, N., & Woody, G.E. for the National Institute on Drug Abuse Clinical Trials Network (2006). Motivational interviewing to improve treatment engagement and outcome in individuals seeking treatment for substance abuse: A multisite effectiveness study. *Drug and Alcohol Dependence, 81,* 301-312.

Carroll, K. & Rounsaville, B. (2003). Bridging the gap: A hybrid model to link efficacy and effectiveness research in substance abuse treatment. *Psychiatric Services, 54*, 333-339.

Hanson, M. & Gutheil, I. (2004). Motivational strategies with alcohol-involved older adults: Implications for social work practice. *Social Work, 49*, 364-372.

Locke, E. A., & Latham, G. P. (1990). *A theory of goal setting and task performance.* Englewood Cliffs, NJ: Prentice Hall.

Lundahl, B. W., Kunz, C., Brownell, C., Tollefson, D., & Burke, B. (2010). Meta-analysis of Motivational interviewing: Twenty five years of research. *Research on Social Work Practice, 20,* 137-160.

Madson, M.B., Loignon, A.C., & Lane, C. (2009). Training in motivational interviewing: A systematic review. *Journal of Substance Abuse Treatment, 36,* 101-109.

Martino S., Ball S.A., Gallon, S.L., Hall, D., Garcia, M., Ceperich, S., Farentinos, C., Hamilton, J., & Hausotter, W. (2006). *Motivational interviewing assessment: supervisory tools for enhancing proficiency.* Salem, OR: Northwest Frontier Addiction Technology Transfer Center.

McIntosh, V.V.W., Jordan, J., McKenzie, J.M., Luty, S.E., Carter, F.A., Carter, J.D., Frampton, C.M.A., & Joyce, P.R. (2005). Measuring therapist adherence in psychotherapy for anorexia nervosa: Scale adaption, psychometric properties, and distinguishing psychotherapies. *Psychotherapy Research, 15*, 339-344.

Miller, W.R., & Mount, K.A. (2001). A small study of training in motivational interviewing: Does one workshop change clinician and client behavior? *Behavioural and Cognitive Psychotherapy, 29,* 457-471.

Miller, W.R., & Rollnick, S. (2002). *Motivational interviewing: Preparing people for change* (2nd ed.). New York: Guildford Press.

Miller, W.R., Sorensen, J.L., Selzer, J.A., & Brigham, G.S. (2006). Disseminating evidence-based practices in substance abuse treatment: A review with suggestions. *Journal of Substance Abuse Treatment, 31*, 25-39.

Miller, W.R., Yahne, C.E., Moyers, T.B., Martinez, J., & Pirritano, M. (2004). A randomized trial of methods to help clinicians learn motivational interviewing. *Journal of Consulting & Clinical Psychology, 72*, 1050-62.

Mitcheson, L., Bhavsar, K. & McCambridge, J. (2009). Randomized trial of training and supervision in motivational interviewing with adolescent drug treatment practitioners. *Journal of Substance Abuse Treatment, 37,* 73-78.

Morgenstern, J. (2000). Effective technology transfer in alcohol treatment. *Substance Use & Misuse, 35*, 1659-1678.

Motivational Interviewing Network of Trainers (2003, November). *Motivational interviewing training new trainers (TNT). Resources for trainers.* Unpublished manuscript.

Motivational Interviewing Network of Trainers (2008, November). *Motivational interviewing training new trainers (TNT). Resources for trainers.* Retrieved July 8, 2010, from the Motivational Interviewing Network of Trainers Web site: http://www.motivationalinterview.org/TNT_Manual_Nov_08.pdf

Shaw, B.F., Elkin, I., Yamaguchi, J., Olmsted, M., Vallis, T.M., Dobson, K.S., Lowery, A., Sotsky, S.M., Watkins, J.T., & Imber, S.D. (1999). Therapist competence ratings in relation to clinical outcome in cognitive therapy of depression. *Journal of Consulting and Clinical Psychology, 67*, 837-846.

Smith, J.L., Amrhein, P.C., Brooks, A.C., Carpenter, K.M., Levin, D., Schreiber, E.A., Travaglini, L.A., & Nunes, E.V. (2007). Providing live supervision via teleconferencing improves acquisition of motivational interviewing skills after workshop attendance. *American Journal of Drug and Alcohol Abuse*, *33*, 163-168.

Walters, S. T., Matson, S. A., Baer, J. S., & Ziedonis, D. M. (2005). Effectiveness of workshop training for psychosocial addiction treatments: A systematic review. *Journal of Substance Abuse Treatment, 29,* 283-293.

ISSN 2160-584X (online) Vol. 1 No. 1 (2012) DOI 10.5195/mitrip.2012.7

Motivational Interviewing
TRAINING · RESEARCH · IMPLEMENTATION · PRACTICE
MITRIP

Delivering Quality Motivational Interviewing Training

A Survey of MI Trainers

Michael B. Madson, PhD[1], Claire Lane, PhD[2], Jeremy J. Noble, BS[1]

Abstract

The MI community places an emphasis on attempting to understand the training process. Yet little is known about what MI trainers perceive as the important variables in training MI. A mixed method survey of 92 members of the Motivational Interviewing Network of Trainers was used to elicit important variables to consider in providing quality MI training. Based on results, it appears that MI trainers are familiar with Miller and Moyers' (2006) eight stages of learning MI and used them to develop trainings. However, the respondents reported that they do not use these stages to evaluate trainings. Moreover, the respondents emphasized the importance of trainee and trainer variables in organizing trainings. They also provided varied opinions regarding the important ingredients in developing MI competency. The authors discuss the need for further empirical exploration of the important training ingredients and the eight stages model. Finally, the need for exploration of how these ingredients help trainees develop competency and future focus on the integration of best practices in adult learning is discussed.

Keywords

motivational interviewing, training

Motivational interviewing (MI) is a counseling approach with more than 20 years of research demonstrating its efficacy with behaviors ranging from substance abuse to promoting healthy lifestyles (Burke, Arkowitz, & Menchola, 2003; Hettema, Steele, & Miller, 2005; Lundahl, Tollefson, Gambles, Brownell, & Burke, 2010). Recently, MI has been defined as "a collaborative, person-centered form of guiding to elicit and strengthen motivation for change" (Miller & Rollnick, 2009, p.137). MI achieves its goals through two components, relational and technical (Miller & Rose, 2009), which are based on the "spirit" and principles of MI (Miller & Rollnick, 2002). With regard to the relational component, MI-consistent providers emphasize a relationship that is empathic and respectful of client autonomy. Further, MI-consistent providers focus on fostering client exploration of values, goals, and concerns. The technical aspects of MI include strategically eliciting and reinforcing change talk through highlighting and exploring discrepancies between client values and goals, and behaviors (Miller & Rose, 2009). MI consistent providers also help the client recognize strengths and assets and roll with client resistance versus directly confronting it.

During the past 25 years, many MI related accomplishments have been made. For instance, many researchers have highlighted the efficacy of MI with a wide variety of behaviors (Hettema et al., 2005; Lundahl et al., 2010). Beyond the evidence of efficacy, a unique characteristic of MI's development has been an emphasis on providing quality training. The need for providing and evaluating quality MI training is strong, as several authors have demonstrated the importance of understanding how clinicians have been trained in and are implementing MI (Dunn, et al., 2001). Further, Madson, Campbell, Barrett, Brondino, and Melchert (2005) suggested that without understanding how clinicians were trained in MI, questions remain about whether providers are actually using MI. This need to understand MI training and MI use was also highlighted by the development of several MI observational measures (Lane et al., 2005; Madson et al., 2005; Madson & Campbell, 2006; Moyers, Martin, Manuel, Hendrickson, & Miller, 2005) and the development of MI training resources (Rosengren, 2009).

Madson, Loignon, and Lane (2009) provided a consolidated review of 27 MI training outcome studies conducted between 1999 and 2006 and found favorable results in relation to (a) confidence using MI, (b) knowledge, (c) increased skill, (d) interest in learning more about MI, (e) intention to use MI, and (f) integration into practice. These findings were supported by Soderlund, Madson, Rubak, and Nilsen (2011), who reviewed MI training with general practice health care professionals. Taken together, these results provide evidence that MI training can produce positive outcomes and provide guidance to the training community about different methods that can be used to appropriately train providers. For instance, Miller, Yahne, Moyers, Martinez, and Pirritano (2004) and Moyers Manuel, Wilson, and Talcott (2007) have emphasized the need for on-going observation and supervision/coaching as the most effective method of MI training. However, these studies have also raised many questions. These questions include: How does one offer quality MI training when the time and resources to provide observation and coaching are not available? What training strategies / methods are more or less useful, what barriers may impact the training design, and how does the Miller and Moyers (2006) model of eight stages of learning MI relate to training?

[1] University of Southern Mississippi [2] University of Birmingham and Wolverhampton City Primary Care Trust

The authors have no conflits of interest to report.

Correspondence concerning this article should be addressed to: Michael B. Madson PhD, The University of Southern Mississippi, Department of Psychology, 118 College Drive #5025, Hattiesburg, MS 39406-5025. E-mail: Michael.madson@usm.edu

ISSN 2160-584X (online) Vol. 1 No. 1 (2012) DOI 10.5195/mitrip.2012.8

EIGHT STAGES / SKILLS OF LEARNING MI

The evolution of MI training has been influenced by Miller and Moyers (2006), who sought to describe the processes involved in developing MI competency which they initially referred to as the eight stages in learning MI. These stages, or skills (Arkowitz & Miller, 2008) include (a) becoming familiar with its underlying philosophy or the "spirit of MI", (b) acquiring basic client-centered counseling skills commonly referred to by the acronym OARS (open questions, affirmation, reflection, summary), (c) recognizing and reinforcing change talk, (d) asking about, reflecting, and emphasize statements concerning change (change talk), (e) avoiding confrontations and arguments with a client (i.e., rolling with resistance), (f) developing a change plan, (g) helping clients enhance their commitment to their change plan, and (h) integrating MI effectively with other interventions (Miller & Moyers, 2006).

This model provides an initial framework for thinking about the important aspects of learning MI based on the experience of its developers and may be beneficial to a number of professionals working with MI. For instance, trainers may be able to structure their trainings and organize how they present information in accordance with the eight stages and thus have a framework for guiding their learning activities. Likewise, the eight stages might be beneficial in providing an empirical foundation for assessing a trainee's progression towards competency. More specifically, evaluation criteria and measures could be developed to guide trainers in assessing the degree to which a trainee has acquired competency in the various aspects of MI. The model may also benefit researchers in designing and formulating their studies. For example, beyond the training and evaluation, the model may help in determining a gold standard to which study providers should be trained. Additionally, the model provides those conducting MI training research with a number of interesting hypotheses that merit further analysis. For instance, it may be beneficial to assess the extent to which trainees can develop competency based on the level of training they receive. It may also be helpful to assess what level of competency could be developed during a standard workshop training versus a more in-depth training as described by Miller and colleagues (2004).

Although the eight stages model appears to have practical merit, it still requires empirical validation before it can be used for these purposes. In fact, the model's authors emphasize that it was developed based on their experiences training MI and not through experimental investigation (Miller & Moyers, 2006). This call for research was further highlighted by Madson and colleagues (2009), who identified several questions related to the eight stages model and found discrepancies in how the model has been addressed in MI training studies. Specifically, the authors found that most studies focused on the first three stages and few training studies addressed the later stages of the model. However, the authors were not able to assess whether trainers were intentionally using the model. Based on these findings, the authors identified several questions relating to the model, including (a) Is the model best conceptualized as a linear stage model or a set of guidelines? (b) To what extent, if at all, does the omission of a stage influence trainee development? (c) What factors influence the inclusion or exclusion of a stage in designing trainings? (d) How are trainers using this model in designing and evaluating trainings?

The purpose of this study is to advance the MI training literature through outlining elements of quality MI training as identified by members of the Motivational Interviewing Network of Trainers (MINT). We sought to answer the questions above and add to the current literature on MI training by eliciting the views of MINT trainers about the important elements to consider when designing an MI training, their thoughts regarding the eight stages model in relation to their experiences of delivering training, and the extent to which the eight stages model is integrated into their current training practices.

METHODS

Participants

Participants were 92 members of the Motivational Interviewing Network of Trainers (MINT). The average age was 47.34 (SD = 10.04). The majority of participants (n = 64) were from North America (69.6%), with 26 from Europe (28.3%) and 1 participant from South America (1.1%) and Africa (1.1%) each. A large majority of participants (n = 83, 90.2%) were White, with 5 (5%) Hispanics, 2 (2%) Asians, 1 (1%) Native American, 1 (1%) African American. Forty-three (46.7%) participants held doctoral degrees (this includes both research and practice degrees), 38 (41.3%) participants held master's degrees, 7 (7.6%) held medical degrees, and 4 (4.4%) had bachelor's degrees. Occupations of participants included 25 (27.2%) researchers or academics, 13 (14.1%) practicing psychologists, 10 (10.9%) administrators, 10 (10.9%) professional trainers, 8 (8.7%) practicing physicians, 7 (7.6%) psychotherapists or counselors, 7 (7.6%) consultants, 6 (6.5%) social workers, 3 (3.3%) allied health professionals, 2 (2.2%) criminal justice workers, and 1 (1.1%) student. On average participants spent 19.4% (SD = 26.1) of their time conducting research, 27.7% (SD = 21.5) teaching, 38.0% (SD = 25.6) providing clinical services, 14.8% (SD = 15.1) providing supervision. Participants have practiced MI for an average of 10.1 years (SD = 5.6), have on average conducted 79.8 (SD = 128.1) MI trainings and been a member of MINT for an average of 5.7 (SD = 5.3) years.

Procedure

Participants were recruited using a snowball sampling technique to maximize recruitment of participants who may not have received our original request. First, individual e-mail messages were sent to selected members of the MINT asking them to pilot-test the Motivational Interviewing Trainer Questionnaire. Next, an e-mail was sent to the MINT listserv providing an open call for participation in the study and asking them to send the message to other MINT members who may not be subscribed to the listserv.

The above e-mail messages explained the study's purpose, procedure, approximate length of time for completing the survey, a link to the on-line survey, and how to contact the principle investigator. The link guided participants to the informed consent page of the survey that explained the study. Participants were informed that participation was voluntary, that no compensation was provided for study participation, and that by completing the survey they were consenting to participate in the study. Participants were asked to complete this on-line survey using the Survey Monkey program. The survey included a demographic form and the 82 item (quantitative – forced choice and qualitative open response) Motivational Interviewing Trainer Questionnaire.

Measures

Motivational Interviewing Trainer Questionnaire (MITQ)

The authors created the MITQ for this study in order to measure participants' perceptions about the important factors and processes related to providing quality MI training. Criteria were developed based on the Miller and Moyers (2006) model of eight stages of learning MI and the first two authors' experience with providing MI training. After reviewing Miller and Moyers (2006) and articles cited in Madson and colleagues (2009), two authors with MI training experience independently generated statements that sought to assess the pragmatism and theoretical structure of this model in designing, conducting, and

ISSN 2160-584X (online) Vol. 1 No. 1 (2012) DOI 10.5195/mitrip.2012.8

Table 1

Elements of training by level of training

Training Element	Introductory N (%)	Intermediate N (%)	Advanced N (%)	Intro & Intermediate N (%)	Intro & Advanced N (%)	Intermediate & Advanced N (%)	All 3 levels N (%)	Not Important N (%)
Review Printed Materials	15 (18.8)	2 (2.5)	2 (2.5)	9 (11.3)	2 (2.5)	8 (11.3)	29 (36.3)	13 (16.3)
Viewing training videos	5 (6.1)	3 (3.7)	--	15 (18.3)	15 (18.3)	2 (2.4)	54 (65.9)	--
Exposure to basic MI concepts	36 (43.9)	2 (2.4)	--	27 (32.9)	--	1 (1.2)	16 (19.5)	--
Simple exercises	44 (53.7)	--	--	22 (26.8)	--	--	16 (19.5)	--
Understanding of MI spirit	7 (8.5)	1 (1.2)	--	27 (32.9)	--	--	46 (56.1)	1 (1.2)
Understanding of the Method of MI	8 (9.9)	4 (4.9)	2 (2.5)	19 (23.5)	--	9 (11.1)	38 (46.9)	1 (1.2)
Personal performance feedback	1 (1.2)	--	4 (4.9)	--	2 (2.4)	32 (39.0)	43 (52.4)	--
Providing individual coaching	--	3 (3.7)	8 (9.8)	4 (4.9)	2 (2.4)	31 (37.8)	33 (40.2)	1 (1.2)
Learning how to learn MI ongoing practice	3 (3.7)	2 (2.5)	8 (9.9)	12 (14.8)	1 (1.2)	16 (19.8)	39 (48.1)	--
Offering extended practice opportunities	--	5 (6.1)	8 (9.9)	3 (3.7)	3 (3.7)	28 (34.1)	35 (42.7)	--
Shaping change talk and commitment language	--	7 (8.5)	4 (4.9)	3 (3.7)	2 (2.4)	42 (51.2)	24 (29.3)	--
Coding session tapes	--	4 (4.9)	18 (22.0)	3 (3.7)	3 (3.7)	32 (39.0)	21 (25.6)	1 (1.2)
Less didactic material	4 (5.1)	1 (1.3)	8 (10.1)	2 (2.5)	1 (1.3)	23 (29.1	38 (48.1)	2 (2.5)
Differentiating change and commitment talk	4 (4.9)	8 (9.9)	17 (21.0)	4 (4.9)	4 (4.9)	32 (39.5)	10 (12.3)	2 (2.5)
Teaching others MI	--	--	48 (59.3)	--	--	25 (30.9)	4 (4.9)	4 (4.9)
Supervision & consultation	1 (1.2)	--	11 (13.4)	1 (1.2)	3 (3.7)	15 (18.3)	51 (62.2)	--
Eliciting change and commitment talk	3 (3.7)	5 (6.1)	1 (1.2)	9 (11.0)	--	25 (30.5)	39 (47.6)	--

evaluating trainings. In an attempt to gain a more comprehensive assessment of respondents' answers, the authors developed forced choice and open response items.

The MITQ included general items which asked participants about conducting MI trainings such as (a) what factors (e.g., setting, audience) influence how they design a training, (b) familiarity with the eight stages model, and (c) activities (e.g., reading, experiential exercise) they believe should be included at specific levels of training (e.g., introductory, intermediate, advanced). These levels and activities were based on descriptions available on the MINT website (MINT, 2009). Examples of pragmatism items include "To what extent do you integrate experiential learning activities based on the eight stages?" and "To what extent do you believe the eight stages model is helpful in designing trainings?" Pragmatism-related items were answered using a 4 point Likert-type scale (1= not at all, 4 = to a great extent). Examples of theoretical structure questions included "To what degree do you agree that each stage of the eight stage model should be achieved before moving on to the next?" and "To what degree do you agree that a trainee should develop competency in the spirit of MI before learning about other topics?" Respondents answered theoretically based questions on a 4 point Likert-type scale (1 = strongly disagree, 4 = strongly agree). Basic descriptive analyses were conducted with these data.

Open response items included questions such as, "Drawing on your experiences in providing training in MI, what, if anything, would you modify in the eight stages model?" and "What do you find most/least helpful about the eight stages model?" The responses from these questions were analyzed using thematic analysis (Braun & Clarke, 2006). Themes within these data were generated inductively, by two independent raters who read through the data several times, and noted similarities and differences between responses to each question. From this, recurring themes were noted. Data were then coded into these overarching themes for interpretation.

RESULTS

Important Ingredients to Consider in Designing and Delivering MI Training

Closed responses

Participants were asked to identify the factors that impact the foci of their trainings. Time constraints seemed to be the most important factor as 69 participants reported this affects their trainings "somewhat" or "to a great extent". Time constraints was followed by training goals (n = 68), trainee prior MI experience (n = 66) or knowledge (n = 65), self confidence with MI (n = 58), attitude toward MI (n = 57), population trained (n = 56) and training environment (n = 52). Table 1 provides participants' responses concerning the types of training activities they believe are important for different levels of training (introductory, intermediate, advanced or a combination of the three).

Open responses

Table 2 provides frequencies and example statements of participants who represented a particular theme for open responses. Eighty-three participants provided free text responses regarding factors that impact trainings. Although various ideas were represented in open responses, we present the most frequently occurring themes here. Three themes supported the responses provided in the quantitative data ('professional context of the trainees', 'prior skill/experience/knowledge of MI' and 'time available for training'). Two additional themes also arose from the open responses. Twenty-nine percent of the responses fell within the theme of trainee needs, goals, or wishes. These data seemed to reflect a tension between what the trainer feels is essential to teach, addressing the needs of the trainees, and the goals to be achieved through practicing MI. Twenty-two percent of responses referred to factors relating to the trainer, including what they felt comfortable delivering, previous experiences and feedback from training MI, and the discussion/sharing of ideas with other MI trainers.

Seventy-five participants also provided open responses on what they felt were the most influential factors in trainees learning MI. The most frequently occurring theme, accounting for 39% of responses, was trainees' experiential learning of MI. In most cases, this referred to trainees experiencing MI in the practitioner role. Thirty-six percent of

ISSN 2160-584X (online) Vol. 1 No. 1 (2012) DOI 10.5195/mitrip.2012.8

Table 2

Open response themes, frequencies and example comments

Area	Themes	N (%)	
Factors that impact training	Professional context of trainees	42 (50)	"If you mismatch the presentation [for example] using examples of 50 minute therapy style sessions in a medical clinic, MI could be discounted prior to even giving it a chance and experiencing its effectiveness in brief encounters."
	Trainee prior knowledge/skill/experience	39 (47)	"[Those trainees] who are new to a counselling field find [MI] more difficult. So, I might move on more quickly to forming reflections with a group of experienced therapists but do some preliminary exercises with those who have little experience."
	Time available for training	28 (34)	"Half a day versus two days require very different agendas."
	Training needs/goals/wishes	24 (29)	"What [the provider]... hope[s] to accomplish with the training and orienting the materials to address that need."
	Trainer factors	18 (22)	"[Using training] exercises that I enjoy. I teach better when I am having fun, and the trainees are having fun too."
Most influential factors in learning MI	Experiencing MI	29 (39)	"Delivering and being on the receiving end of MI... combined with debriefing of experience[s] and questions and answers. This helps people 'get it' (in their guts) and surfaces their assumptions, [and] helps them feel understood (or not), feel resistance, notice change talk, notice their tendencies [such as] jumping in [and] the righting reflex."
	Motivation/openness	27 (36)	"Those who are willing to learn [MI] get it more quickly. Trainees who are highly resistant may need many exposures to even start to understand and accept the model."
	Trainer	24 (32)	"Conveying and accepting, open, questioning attitude on the part of the trainer (modelling the spirit) can facilitate the development of this mindset in the participant."
	Predisposition of trainee	22 (29)	"Openness and genuineness. I think that is part of someone's personality and you can't teach it... I can teach them a lot of academic stuff... [but] you can't teach someone compassion."
	On-going support	21 (28)	"No matter [who] is conducting the training, without supervision it (most of the time) means nothing. People can be so good during the training and a couple of weeks later are not doing any... MI."
Training others based on 8 stages model	Existing order is logical/makes sense	17 (36)	"It seemed to make logical sense even before the article came out, and was how I was taught in my [MINT Training for New Trainers]."
	Flexibility of model	13 (27)	"I don't always stick to this order. I will switch around if the trainee group needs indicate this to be appropriate."
	Spirit of MI first	13 (27)	"People need to understand how to be in the spirit first."
	Rolling with resistance	10 (20)	"I think much of rolling with resistance is linked to reflections so it fits better before change talk which I see as a more intermediate level of training. Plus if you cannot manage resistance you won't get to change talk!"
Actively incorporating 8 stages model into training	Framework/structure/plan	35 (54)	"The stages give trainees a way to measure their own progress or decide what skill areas they need to work on. It gives supervisors specific ideas for skill building and case consultation when they work with staff. This model has been helpful for me when I train trainers who are not teaching MI as a subject area, but work with staff who are often sceptical and reluctant to accept new training initiatives in general."
	Doing so before article though not purposefully	12 (19)	"The 8 stages model is a consolidation of training wisdom developed over a decade or more. I developed my approach to MI training long before this model was articulated... My approach is largely consistent with it, [but I did not learn] how to order my trainings from that article."
	Limitations of 8 stages model	9 (14)	"I think [the 8 stages model] is based on a narrow conception of what MI is. I spend much more time in workshops helping trainees to understand and resolve ambivalence. In some workshops I spend more time working with the concept of discrepancy. I think it is a funny idea that one can train 'spirit' as a first stage. It is rather an attitude that runs throughout the entire training."
Most useful aspects	Utility/map/guide	32 (60)	"It provides a clear framework for teaching and learning MI, but I am not sure it is the only or best framework, just the one I am most familiar with."
	Logical	6 (11)	"[The 8 stages model is] organised, and appears to be in a fairly logical order."
	Elements to include in trainings	5 (9)	"[The 8 stages model provides] a useful categorisation of the content to be covered in training."
Least helpful aspects	Knowing how to use it	11 (26)	"Just that folks remember this is a model, not the bible."
	Inflexibility of order	11 (26)	"The stage based nature of this model inhibits flexibility,"
	Loss of richness in learning MI	5 (12)	"Stage models are reductionistic, overly simplistic, and often create an assumption of veracity without the data to support this."
How model could be modified	Guidance on how to use it	16 (47)	"I think it is a great map of how to learn MI, but it is just a map, meaning you don't have to follow it in the direct order or even train all the stages. [This] is helpful to me... I would not change it at all, but give more guidance on how to use it."
	Overlapping processes	10 (29)	"Even the '8 learning tasks' is too discrete, although I understand its usefulness as a model. People learn in different, overlapping ways."
	Missing elements	9 (27)	"Where's ambivalence? The loss of this central organising feature of MI in favour of a stronger focus on change talk makes MI less valuable in my opinion."
	Sequence of stages	6 (18)	"I think it is a great map of how to learn MI, but it is just a map, meaning you don't have to follow it in the direct order or even train all the stages. [This] is helpful to me... I would not change it at all, but give more guidance on how to use it."

Note: Percentages do not add up to 100% per domain as some participants may not have provided answers that fit that domain.

ISSN 2160-584X (online) Vol. 1 No. 1 (2012) DOI 10.5195/mitrip.2012.8

respondents also made reference to the motivation of the trainees to change their current practice as being influential in learning MI. Thirty-two percent of responses suggested the trainer was highly influential in impacting the learning of MI. In most cases, responses suggested that the trainer should attempt to train others in a style reflective of MI skill and spirit.

Twenty-nine percent of respondents suggested that some learners are in some way better 'predisposed' to learn MI which impacted their learning of the method. This mainly referred to some kind of 'inner quality' and/or beliefs held by the trainee and the degree to which these qualities and beliefs are commensurate with an MI approach. Twenty-eight percent of the responses referred to an ongoing support mechanism being the most influential factor in trainees learning MI. In most cases, this referred to feedback and supervision in practice, but the supportiveness of the working environment to integrating MI was also identified as important.

Familiarity with and Utilization of the Eight Stages Model

Closed responses

Participants reported relatively strong exposure to the eight stages in learning MI. In fact, 76 participants reported that they at least "somewhat" understand the eight stages of learning MI. The majority of participants (n = 66) reported that they have read the Miller and Moyers (2006) article describing the eight stages in learning MI. Further, 54 participants indicated that they have observed some discussions by MINT members using the eight stages during their trainings or have been at least somewhat encouraged by colleagues to consider the eight stages in designing trainings (n = 48).

Sixty-three participants suggested that they aim to incorporate the eight stages into their trainings and 55 participants reported training others in a particular order based on the eight stages. For those who sequence their trainings based on the eight stages, a majority suggested that they should proceed in the following order: the Spirit of MI be addressed first (n = 55), followed by OARS (n = 49), rolling with resistance (n = 31), recognizing and reinforcing change talk (n = 30), eliciting and strengthening change talk (n = 30), consolidating a client commitment (n = 32), developing a change plan (n = 30), and switching between MI and other methods (n = 52).

Participants expressed wide variability in the extent to which they consider the eight stages in regard to specific training activities. Although most participants (n = 57) use the eight stages in designing their trainings, few (n = 42) present the model to participants, indicating either "a very little" or "not at all". A majority of respondents (n = 58) integrate experiential activities in trainings at least "somewhat" based on the eight stages.

Respondents were quite diverse in their use of the eight stages when providing supervision/coaching. Thirty-two participants reported using the eight stages only "a little" or "not at all," while 41 participants used the eight stages at least "somewhat" in providing supervision. Similarly, slightly more than half of the participants (n = 40) indicated using the eight stages at least "somewhat" in evaluating trainees' progress, yet the majority of participants (n = 52) use the eight stages in evaluating training outcomes "very little" or "not at all."

When asked how helpful the eight stages are, the strong majority of participants suggested that they are at least "somewhat" helpful (n = 68) in general as well as in tailoring trainings for specific groups (n = 56). Furthermore, participants indicated that the eight stages are at least "somewhat" helpful (n = 61) in helping trainees understand the process of learning MI. The majority of participants indicated that the eight stages are at least "somewhat" helpful for them in deciding which MI skills may require additional training (n = 59), providing supervision (n = 56), and evaluating trainee progress (n = 54). However, there seems to be more variability among participants in regard to the helpfulness of the eight stages in assessment. For instance, 32 participants indicated the eight stages help them "very little" to "not at all" in assessing outcomes of their trainings, with similar results for assessing the integrity of trainee application of MI (n = 30). Thirty-three participants reported that they conduct research as a regular part of their occupation. Of these participants, 17 indicated that they use the eight stages "very little" to "not at all" in designing studies.

Open responses

Forty-nine participants provided free text responses to the question regarding the order that they choose (or not) to teach using the eight stages model. Their responses centered around four themes (logical order, flexibility of order, MI Spirit and rolling with resistance). About 36% of responses referred to the logic of the existing order of the eight stages model. Participants often referred to this in regard to their own experiences of training MI and made parallels to practicing MI with a client. Despite this support for the logic of existing order in which the eight stages model is currently presented, 27% of respondents also stated that they felt the order of the model is flexible. This involved reference to moving specific stages around trainee needs and using this model in conjunction with others during the training process. Twenty-seven percent of responses discussed MI spirit, in most cases suggesting that this should be the first step in teaching/learning MI. Twenty percent of responses suggested that rolling with resistance is a stage that some prefer to teach earlier.

Sixty-five participants responded to the free text question about incorporating the eight stages model into their trainings. Their responses centered around three themes ('model as a framework', 'incorporating it all already' and 'limitations of the model'). Fifty-four percent of the responses referred to the model in terms of providing a framework, structure, or plan for MI training. This related both to providing a structure for the trainer in terms of what to incorporate into trainings, to help provide a framework for providing supervision, and also to providing trainees and other trainers with a framework with which to interpret their own learning. Nineteen percent of responses suggested that participants felt that to an extent they were already incorporating the eight stages model into their training, though not always purposively. One final theme that arose out of 14% of responses was participants' thoughts and experiences of the limitations of the eight stages model. These responses aired concerns about the validity of these stages, and discussed other ways to teach MI not included in the model (such as by teaching about ambivalence and developing discrepancy). It was also highlighted that the model was not 'learner centered' in its development.

MI Trainers' Beliefs about the Eight Stages

Closed responses

In an attempt to gain greater insight into MI trainers' view of the eight stages in relation to trainee development of MI competency, participants were asked several questions about the structure of the eight stages. A majority of participants (n = 60) disagreed or strongly disagreed that competency at each stage, as outlined by Miller and Moyers (2006), should be achieved prior to moving to the following stage. As such, the majority of participants (n = 62) indicated that the eight stages are better conceptualized as learning tasks than stages and that trainees should not have to master them in a specific order (n = 63). However, when asked about the relationship between the specific stages "trainee" and "competency," there was a sizeable amount of variability found among trainers as seen in Table 3.

ISSN 2160-584X (online) Vol. 1 No. 1 (2012) DOI 10.5195/mitrip.2012.8

Table 3

MINT members' attitudes on the appropriate progression of training

Statement	Strongly Disagree N (%)	Disagree N (%)	Agree N (%)	Strongly Agree N (%)
Trainees should develop competency in the spirit of MI prior to learning about other topics	4 (5.2)	35 (45.5)	21 (27.3)	17 (22.0)
Trainees should develop competency in both the spirit of MI and OARS prior to moving to any other stage	4 (5.2)	30 (39.0)	32 (41.6)	11 (14.2)
Trainee should develop competency in OARS before they are able to adequately roll with resistance	4 (5.2)	24 (31.2)	35 (45.5)	14 (18.1)
Trainees should be able to recognize & reinforce change talk before developing competency in eliciting and strengthening change talk	2 (2.6)	18 (23.4)	37 (48.0)	20 (26.0)
Trainees should develop competency in all 7 other stages before being able to integrate MI with other approaches	10 (13.0)	35 (45.5)	27 (35.0)	5 (6.5)
Prior to being able to develop a change plan trainees should have sufficient knowledge in the MI spirit, OARS, rolling with resistance, and recognizing and eliciting change talk	5 (6.8)	30 (40.5)	36 (48.6)	3 (4.1)
Demonstrating competency in each stage is critical regardless of trainee background	6 (8.1)	28 (37.3)	31 (41.3)	10 (13.3)
Trainees are unable to roll with resistance without developing competency in recognizing and reinforcing change talk	15 (19.7)	53 (69.7)	5 (6.7)	3 (3.9)

Open responses

Thirty-four participants provided a free text response to the question as to what they would modify about the eight stages model. Their responses centered on four themes ('using the model in practice', 'overlap', 'missing elements' and 'order of stages'). The strongest theme appeared to be how to use the model in practice which was featured in 47.1% of responses. The message appeared to be that steps need to be taken to ensure the model is not used rigidly. Some suggested more guidanceshould be given on its use. Twenty-nine percent of responses referred to overlapping elements in the model, suggesting that these cannot be encapsulated by discrete stages. Twenty-seven percent of responses suggested that there were elements missing in the existing model. In most cases, these centered on client ambivalence, readiness, evidence for MI, and empathy. The final theme that emerged in 18% of responses was that participants would like the order in which the eight stages are presented to be altered.

Fifty-three participants provided free text responses describing what they felt was most useful about the eight stages model. Sixty percent of respondents mentioned the eight stages model being useful as a framework, particularly in planning trainings, understanding the training process, and understanding the learning process. Eleven percent of respondents suggested that they found the apparent logical approach of the model useful. Nine percent of respondents made reference to the eight stages model being useful when considering what elements need to be included in training.

Forty-three participants provided free text responses to the question about what they found the least helpful about the eight stages model. Twenty-seven participants provided responses that fit into a theme of knowing how to use the eight stages model. Mostly, responders commented that the model may be interpreted as rigid and linear; 26% of participants suggested that they felt the model was rigid and inflexible. The theme that accounted for 12% of responses was the potential loss of richness in the process of learning MI by reducing it to a model.

DISCUSSION

The purpose of this study was to expand the MI training literature by describing what MI trainers believe to be important in designing and delivering quality MI training, and how the eight stages model relates to their current training practices. We sought to accomplish this by eliciting (a) the important factors related to MI training, (b) the degree of familiarity and thoughts regarding the Miller and Moyers (2006) eight stages model, and (c) trainers' use of the model in training. Ninety-two members of the MINT completed an on-line survey that addressed the three topical areas mentioned above.

Regarding the important elements to include in the development and execution of MI training, based on our results, it appears that MI trainers think it is important to consider both factors related to the trainer (e.g., experience in MI and training MI) in addition to trainee variables (e.g., motivation) and training environment. Furthermore, it appears as though integrating experiential exercises is a highly valued component of MI training even though training goals and constraints may not allow for inclusion of this activity. There is some evidence to suggest that experiential activities are more efficacious in achieving learning outcomes in clinical practice (Thompson O'Brien et al., 2001), though there is currently less evidence as to which kinds of experiential activities specifically are most beneficial (Lane, Hood, & Rollnick, 2008).

It is not necessarily the case that experiential activities have to take longer than didactic activities. Thus, one approach MI trainers might adopt is a consultation approach (Dougherty, 2009). By adopting a consultation approach, a trainer can benefit from assessing training needs of the audience, the organization or training environment, and match this assessment with trainer knowledge and skill in order to provide a tailored training program. The use of a consultation approach has often been implemented when addressing organizational need, and providing training or team building efforts as it helps the consultant appreciate the multitude of factors that may be involved in a request (Dougherty, 2009). Adopting such an approach is one way that may help the trainer navigate the tension that can surface between what the trainer feels is essential to teach, how to train the material, and the needs of the trainee and organization that emerged in our findings.

The results of this study also suggest that participants have become relatively familiar with Miller and Moyers (2006) eight stages of learning MI model through readings, discussions with other MI trainers, and receiving encouragement to learn about the eight stages. Similarly, we found that the majority of participants are incorporating the eight stages into their trainings and find them helpful for designing trainings and experiential training activities. At the same time, variability was found among participants in regard to the extent to which they use the eight stages in relation to various training activities (e.g., clinical supervision). Based on these results, it seems that Miller and Moyers (2006) eight

ISSN 2160-584X (online) Vol. 1 No. 1 (2012) DOI 10.5195/mitrip.2012.8

stages of learning MI are increasing in popularity within the MI training community.

Beyond the need for further scientific validation of the eight stages, our results highlighted some areas of concern. These areas include the use of the eight stages in assessing training outcomes or trainee development and variability among participants as to the important ingredients of the model in relation to MI. One training area in which there was much variability among participants was the use of the eight stages in assessment and training evaluation. We found that the majority of participants reported that the eight stages were “not at all” or “a little helpful” in assessing outcomes of trainings or in the integrity of trainee application of MI. Thus, it appears that while trainers are willing to use the eight stages to design trainings, they are less inclined to use the model to evaluate outcomes or trainee development. There are two ways to interpret these findings: either trainers are not evaluating the outcomes of their trainings or they are not linking outcome to training goals and objectives. Given the increasing importance on evaluating training outcomes (Madson et al., 2009) and developing effective training practices in line with this, it is important for this concern to be addressed by MI trainers and researchers.

One effective model from industrial-organizational psychology for evaluating training was delineated by Kirkpatrick (1977). In outlining the model, Kirkpatrick emphasized the need to establish proof that trainings are accomplishing their objectives in four areas: (a) ‘reaction’ - how participants feel about the training, (b) ‘learning’ - the extent to which trainees learned the information and skills, (c) ‘behavior’ - the extent of behavior change, and (d) ‘results’ – the extent work results have changed due to the training. It is also important to understand what is keeping MI trainers from evaluating outcomes, and for those who do attempt to evaluate their trainings, what is hindering the use of the eight stages in guiding evaluation. Further, it may behoove training researchers to design clinically relevant tools for evaluating outcomes for different training formats (e.g., brief didactic workshop, skill building trainings), perhaps using Kirkpatrick’s (1977) model as a guide.

Our results also highlighted variability among participants regarding their view of the important ingredients relating to the eight stages and the fixed ordering of the model. While the majority of participants suggested that it is important to develop competency in the first seven stages prior to integrating MI with other approaches and that the current order seems logical, a majority also suggested that competency is not required at an earlier stage in order to “move on” to the next stage and that the stages are best viewed as learning tasks. Further, when asked if there was a particular order related to the eight stages, there was variability among respondents. For example, some respondents suggested “rolling with resistance” should come before OARS. Almost a third of participants also suggested that concepts such as client ambivalence, readiness and empathy were missing or underrepresented in the current framework.

These results suggest that while the eight stages model is a good foundation, more work is needed to outline a method of learning MI that emphasizes the fluidity and overlap involved in developing skill in MI. In fact, it may benefit those developing the framework for learning MI to consider focusing on competencies that need to be developed for effective use of MI and potential benchmarks for evaluating progress toward competency versus stages or tasks. For example, the profession of psychology has worked on outlining the competencies and benchmarks at various developmental levels in learning to become a psychologist (Fouad et al., 2009) and in the delivery of specific psychological interventions (Roth & Pilling, 2007). As such, one could look at how a novice trainee may develop across the various MI competencies compared to how a more advanced trainee would develop across the MI competencies. Moreover, development of the MI learning framework may be enhanced by accessing the counselor development literature. For example, the Integrated Developmental Model of counselor development (Stoltenberg, McNeill, & Delworth, 1998) highlights general developmental tasks, challenges, and behaviors that those learning any new counseling skill often experience. As such, this model could be applied to trainees from various professions who may be learning MI as a form of counseling / communication. Thus, it may be valuable to examine the development of MI competency within this framework.

It appears from participant responses that the eight stages model is commensurate with the understanding of best practice in MI training within a particular organization (MINT). It is also striking from the open responses in our survey that teaching MI is often paralleled with MI practice, with many respondents drawing on the discourse of MI as a clinical method to describe trainees and practices in training such as ‘I roll with their resistance’, ‘trainees are the experts in what they need to learn’, ‘I elicit what they know and provide a little extra’, ‘I encourage them to talk about their ambivalence about using MI in their practice’ ‘I affirm their progress’. This perhaps reflects the dominant experiences of the trainers within MINT and highlights the following important limitation: these practices have not been explicitly linked with evidence -based practices in teaching or learning and may simply reflect the dominant views and beliefs of a particular group of trainers (McCauley, 1998; DiMaggio & Powell, 1983; Janis, 1982). All MINT members have been trained by trainers, who have themselves been taught to teach MI in a particular way, based on those trainers’ own beliefs and experiences of learning MI. This may in itself promote a particular way of thinking about MI training within the organization. This may also explain why many of our respondents felt that they were implementing the eight stages model before it was published. There is limited evidence that using any particular method or model of training MI is conclusively superior to another. Yet, it seems that our respondents had very clear ideas about what constituted good practice in MI training and what kinds of training were most beneficial for learners.

This does not necessarily mean that these beliefs are flawed. However, it should be emphasized that although there has been some limited investigation into which training practices seem to lead to better acquisition of MI skills (Miller et al., 2004), there is very limited evidence regarding which training variables bring about the best learning outcomes in MI training. There has also been little critical evaluation of the MI training practices assessed and discussed by the participants in this study. Future studies related to the development of the eight stages of learning framework may seek to integrate existing information on skill development, counselor development (Stoltenberg et al., 1998), adult learning (Bransford, 2000) and evidence-based curriculum development (Clements, 2007) to provide a more robust and scientifically sound learning framework.

It would also be beneficial to look more at how best to assess learning outcomes from MI training, and to perhaps attempt to build evidence that these commonly held beliefs/experiences are indeed the best practices to use when teaching/learning MI. Once a more scientifically sound framework has been developed, researchers may consider making an effort to connect specific MI training activities to the MI learning framework, as well as design clinically relevant evaluation tools to help researchers and trainers evaluate outcomes and connect them to the learning framework.

While our results have helped us to further understand the important MI training ingredients and the trainer view of Miller and Moyers (2006) model, study limitations call for caution in interpreting results. The most notable of these limitations is the representativeness of the sample. Though MINT is an international group with representation from a wide variety of countries worldwide, the majority of our sample (69%) was from the United States, thus limiting the diversity of thought

ISSN 2160-584X (online) Vol. 1 No. 1 (2012) DOI 10.5195/mitrip.2012.8

and responses. Additionally, the use of semi-structured interview data versus short answer to questions may have provided richer insight as a result of follow up questions, the raising of additional important topics, or ensuring the researchers understood the points made by a participant. Thus, our short answer method may not have fully captured a participant response. Future studies should be conducted with international samples and in languages in addition to English to enable better understanding and ease of response. It would also be beneficial to conduct a similar study as this with a more diverse sample of MINT members, utilizing interviews to extract richer, more detailed, qualitative data.

Finally, it should also be noted that this study looks at trainers' perspectives rather than the experiences of the learner. Further studies of trainee experiences of learning MI may also shed light on which training practices seem to work best for whom, and in what circumstances (Pawson & Tilley, 1997).

REFERENCES

Adams, J. B., & Madson, M. B. (2006). Reflection and outlook for the future of addictions treatment and training: An interview with William R. Miller. *Journal of Teaching in the Addictions, 5*, 95-109.

Arkowitz, H., & Miller, W.R. (2008). Learning, applying, and extending motivational interviewing. In H. Arkowitz, H. Westra, W. R. Miller, & S. Rollnick (Eds.), *Motivational interviewing in the treatment of psychological problems*. New York: Guilford Publications.

Bransford, J. D., Brown, A. L., & Cocking, R. R. (2000). *How people learn: Brain, mind, experience, and school.* Washington,DC: National Academy Press.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative research in psychology, 3*, 77-101.

Burke, B. L., Arkowitz, H., & Menchola, M. (2003). The efficacy of motivational interviewing: A meta-analysis of controlled clinical trials. *Journal of Consulting and Clinical Psychology, 71*, 843-861.

Clements D. (2007). Curriculum research: Toward a framework for 'Research-based Curricula'. *Journal for Research in Mathematics Education, 38*, 35-70.

DiMaggio, P. J. & Powell, W. (1983) The iron cage revisited: institutional isomorphism and collective rationality in organizational fields. *American Sociological Review*, 48, 147-60.

Dougherty, A. M. (2009). *Psychological consultation and collaboration in school and community settings (5th ed).* Belmont, CA: Brooks/Cole Publishing.

Dunn, C., Deroo, L., & Rivara, F. P. (2001). The use of brief interventions adapted from motivational interviewing across behavioral domains: A systematic review. *Addiction, 96*, 1725-1742.

Fouad, N. A., Grus, C. L., Hatcher, R. L., et al. (2009). Competency benchmarks: A model for understanding and measuring competence in professional psychology across training levels. *Training and Education in Professional Psychology*, *3 (supplement)*, S5-S26.

Hettema, J., Steele, J., & Miller, W.R. (2005). Motivational interviewing. *Annual Review of Clinical Psychology*, *1*, 91-111.

Janis, I. L. (1982). *Groupthink: Psychological studies of policy decisions and fiascoes.* Second Edition. New York: Houghton Mifflin.

Kirkpatrickk, D. L. (1977). Evaluating training programs: Evidence vs. proof. *Training and Development Journal, 31*, 9-12

Lane C., Hood K., Rollnick S. (2008). Teaching motivational interviewing: Using role-play is as effective as using simulated patients. *Medical Education*, 42, 637-644.

Lane, C., Huws-Thomas, M., Hood, K., Rollnick, S, Edwards, K., & Robling, M. (2005). Measuring adaptations of motivational interviewing: The development and validation of the behavior change counseling index (BECCI). *Patient Education and Counseling, 56,* 166-173.

Lundahl, B.W., Tollefson, D., Kunz, C., Brownell, C., & Burke, B. (2010). Meta-analysis of Motivational interviewing: Twenty five years of research. *Research on Social Work Practice, 20,* 137-160.

Madson, M. B., & Campbell, T. C. (2006). Measures of fidelity in motivational enhancement: A systematic review. *Journal of Substance Abuse Treatment, 31*, 67-73.

Madson, M. B., Campbell, T.C., Barrett, D.E., Brondino, M.J., & Melchert, T.P. (2005). Development of the motivational interviewing supervision and training scale. *Psychlogy of Addictive Behaviors*, *19*, 303-310.

Madson, M. B., Loignon, A. C., & Lane, C. (2009). Motivational interviewing training: A systematic review. *Journal of Substance Abuse Treatment*.

Martino, S., Ball, S. A., Nich, C., Carroll, K. M., & Frankforter, T. L. (2008). Community program therapist adherence and competence in motivational enhancement therapy. *Drug and Alcohol Dependence, 96*, 37-48.

McCauley, C. (1998). Group dynamics in Janis's Theory of groupthink: Backward and forward. *Organizational Behavior & Human Decision Processes, 73*(2-3), 142-162.

Miller, W. R., & Moyers, T. B. (2006). Eight stages in learning motivational interviewing. *Journal of Teaching in the Addictions*, *5*, 3-17

Miller, W. R., & Rollnick, S. (2009). Ten things motivational interviewing is not. *Behavioural and Cognitive Psychotherapy, 37*, 129-140.

Miller, W. R, & Rollnick, S. (2002). *Motivational interviewing: Preparing people for change.* (2nd ed.) . New York : The Guilford Press.

Miller, W. R., & Rose, G. S. (2009). Toward a theory of motivational interviewing. *American Psychologist, 64*, 527-537.

Miller W, Yahne, C., Moyers T, Martinez J & Pirritano M (2004). A randomized trial of methods to help clinicians learn motivational interviewing. *Journal of Consulting and Clinical Psychology*, 72, 1050-62.

Miller, W. R., Zweben, J., & Johnson, W. R. (2005). Evidence based treatment: Why, what, where, when, and how? *Journal of Substance Abuse Treatment, 29*, 267-276.

Motivational Interviewing Network of Trainers (2009). *Training information*. Retrieved on May 3, 2009 from http://motivationalinterview.org/training/expectations.html

Moyers, T. B., Martin, T., Manuel, J. K., Hendrickson, S. M. L., & Miller, W. R. (2005). Assessing competence in the use of motivational interviewing. *Journal of Substance Abuse Treatment, 28*, 19-26.

Nicolai, J., Demmel, R., & Hagen, J. (2007). Rating scales for the assessment of empathic communication in medical interviews (REM): Scale development, reliability, and validity. *Journal of Clinical Psychology in Medical Settings, 14*, 367-375.

Pawson, R. and Tilley, N. (1997). *Realistic evaluation*. London: Sage Publications.

Rosengren, D. B. (2009). *Building motivational interviewing skills: A practitioner workbook*. New York: Guilford Press.

Roth, A. D. And Pilling, S. (2007) *The competences required to deliver effective cognitive and behavioural therapy for people with depression and with anxiety disorders.* Department of Health, UK. Retrieved from: www.dh.gov.uk/publications

ISSN 2160-584X (online) Vol. 1 No. 1 (2012) DOI 10.5195/mitrip.2012.8

Söderlund, L. L., Madson, M. B., Rubak, S., & Nilsen, P. (2011). A systematic review of motivational interviewing training for general healthcare practitioners. *Patient Education and Counseling, 84,*16-26.

Stoltenberg, C. D., McNeill, B., & Delworth, U. (1998). *IDM supervision: An integrated developmental model for supervising counselors and therapists*. San Francisco: Jossey-Bass Publishers.

Thomson O'Brien M, Freemantle N, Oxman A, Wolf F, Davis D, Herrin J. (2001). Continuing education meetings and workshops: Effects on professional practice and health care outcomes (review). *Cochrane Database of Systematic Reviews* (Issue 1).

ISSN 2160-584X (online) Vol. 1 No. 1 (2012) DOI 10.5195/mitrip.2012.8

Motivational Interviewing
TRAINING · RESEARCH · IMPLEMENTATION · PRACTICE
MITRIP

Coding Criminal Justice Interactions with the MITI

Recommendations for Research and Practice

Scott T. Walters, PhD[1], Malissa Cornett, MPH[1], Amanda M. Vader, MPH[1]

Abstract

This article describes the coding portion of a study to test the effectiveness of a motivational interviewing (MI) training program for probation officers. We describe some of the challenges with using the Motivational Interview Treatment Integrity (MITI) instrument to code interactions between probation officers and clients. Our team of raters was able to obtain adequate inter-rater reliability on most MITI scales, though reliability ratings on some of the specific behavior counts such as Giving Information, MI Adherent, and MI Non-adherent fell considerably lower than the original MITI norming study. Our results suggest that the MITI is a mostly reliable instrument for coding criminal justice interactions, though there were exceptions to this rule. Based on our experiences, we discuss some of the ways that probation interactions might be different from traditional counseling interactions, and identify some rules of thumb that helped us to code interactions. We end with suggestions for how MITI feedback can be used effectively in training and supervision in criminal justice and other non-traditional settings.

Keywords

motivational interviewing, criminal justice, MITI, coding

As motivational interviewing (MI) becomes more widely disseminated, there has been a need for standardized measures to assess MI performance The Motivational Interviewing Treatment Integrity (MITI 3.1; Moyers, Martin, Manuel, Miller, & Ernst, 2009) coding system was designed to be used as a treatment integrity measure for clinical trials of MI, as well as a method of providing structured feedback to providers in non-research settings. The MITI evaluates *global characteristics* of the counseling session (i.e., Evocation, Collaboration, Autonomy-supportive [often grouped together as MI Spirit], Empathy, Direction) on a scale of 1-5, as well as *specific counselor utterances* (e.g., giving information, asking open and closed questions, offering simple and complex reflections, confronting [MI Non-adherent], affirming [MI Adherent]) that may be consistent or inconsistent with MI. The MITI manual also suggests threshold scores for evaluating MI competence; *beginning proficiency* is defined as at least 3.5/5.0 on the global ratings, a 1:1 ratio of reflections to questions, at least 50% open questions, and 40% complex reflections, whereas *competency* is defined as at least 4.0/5.0 on the global ratings, a 2:1 ratio of reflections to questions, at least 70% open questions, and 50% complex reflections.

Previous studies have found the MITI to be a reliable measure of MI skill, with inter-rater reliability ratings in the good-to-excellent range on most subscales (Bennett, Moore, et al., 2007; Bennett, Roberts, Vaughan, Gibbins, & Rouse, 2007; Moyers, Martin, Manuel, Hendrickson, & Miller, 2005; Pierson, et al., 2007; Thyrian, et al., 2007). One advantage of the MITI over simple clinical impression is that the MITI provides objective information on what are considered to be the most crucial aspects of MI. In addition, the MITI manual contains anchor scores and norms against which to compare clinician performance for purposes of supervision and quality control. Studies tend to find substantial agreement between patient and observer ratings of MI skill, and that certain aspects of MITI-rated performance predict better client outcome (Bennett, Roberts, Vaughan, Gibbins, & Rouse, 2007; Pierson, et al., 2007; Tollison, et al., 2008). For instance, Tollison et al. (2008) found that the frequency of open questions and complex reflections both predicted drinking outcome in a group of heavy drinking college students. In other studies, global characteristics such as empathy positively predicted client change talk and a more favorable outcome (Boardman, Catley, Grobe, Little, & Ahluwalia, 2006; Moyers, Miller, & Hendrickson, 2005).

Originally, MI was conceived as a counseling interaction focused on a single target behavior, such as drinking, and it is in settings such as this that the MITI has mostly been normed. Despite a growing interest in using the MITI to code other kinds of interactions, such as healthcare, social work, or criminal justice interactions, there has been relatively little research on the reliability or validity of the MITI in these settings. In fact, we were unable to locate a single published study establishing the reliability of the MITI in criminal justice interactions. As we argue below, these settings may differ from more traditional counseling interactions in

[1]At the time the research was conducted, the authors were affiliated with the University of Texas School of Public Health.

This project was funded through a cooperative agreement with the National Institute on Corrections (07C71GJS8, PI: Walters). The authors gratefully acknowledge the contributions of Steven Brazill, Ray Gingerich, Terri Thomas, and the 30 probation officers who helped to implement this project.

The authors have no conflict of interest to declare.

Correspondence concerning this article should be addressed to: Scott T. Walters, PhD, University of North Texas Health Science Center, 3500 Camp Bowie, EAD 711, Ft. Worth TX 76107. Email: Scott.Walters@UTSOUTHWESTERN.EDU

ISSN 2160-584X (online) Vol. 1 No. 1 (2012) DOI 10.5195/mitrip.2012.9

several respects, and pose difficulties for adequately coding and interpreting MITI scores.

This article draws from the coding portion of a randomized trial to test the effectiveness of MI as a strategy for probation supervision in a large urban probation department. In the U.S., probation is the largest segment of the criminal justice system. Probation officers, the main contact for clients in the probation system, meet with clients to monitor progress, assess risk, and motivate clients to make changes that are consistent with conditions that have been specified by the Court. In this paper, we begin by briefly summarizing the results of our coding process. We then note some of the challenges we encountered when using the MITI to code probation officer interactions and offer recommendations for alterations in the MITI to improve its fit in criminal justice settings. We end with suggestions for how MITI feedback can be used effectively in training and supervision in criminal justice and other non-traditional settings.

OVERVIEW OF THE PROJECT

Enhancing Compliance and Officer Responsively (ENCORE) was a randomized effectiveness trial of MI as a probation supervision strategy. The project has been described more extensively elsewhere (Walters, Vader, Nguyen, Harris, & Eells, 2010). Briefly, 20 probation officers who were interested in receiving MI training were randomized to MI-trained or MI-untrained groups. The MI training sequence for trained officers consisted of an initial two day training, followed by two half-day trainings and monthly supervision throughout a four month period during which officers submitted interview tapes for review and critique. The MI-untrained group did not receive any training during the study period. All officers completed two standardized role play interactions at three timepoints: baseline, two months, and six months. Each role play interaction (available from the authors upon request) described a medium-to-high risk probation case that involved compliance with substance abuse treatment, anger management, or other probation requirements. Officers were given a background and history on the case and instructed to conduct the interaction as if it were a real probation office visit.

Coding was conducted by three raters who were blind to study condition and timepoint. Training for the coders included an initial two day workshop consisting of practice tapes, videos, and manuscripts that focused on the coding protocol stated within the MITI manual. Both the senior author of this paper (STW) and lead coder (AMV) had previously completed a MITI training workshop with Dr. Theresa Moyers. Before coding actual project tapes, raters coded approximately ten practice tapes each over 60 days until adequate inter-rater reliability was obtained. Weekly meetings between the coders continued throughout the project, and a randomly selected 20% of tapes were coded by all coders. Intraclass correlation coefficients (ICCs) ranged from fair to excellent (Cicchetti, 1994; Shrout & Fleiss, 1979). Table 1 shows how our ICC results compared to the original MITI reliability study conducted by Moyers et al. (2005). In general, while our global reliability ratings compared favorably to Moyers et al. (2005), some of the specific behavior counts such as Giving Information, MI Adherent, and MI Non-adherent fell considerably lower than the original study.

As described elsewhere (Walters et al., 2010), the MI training sequence resulted in significant overall improvements in fidelity to MI compared to the group that did not receive the training. For instance, from baseline to 6 months, mean Empathy scores increased from 2.50 to 3.50 (out of 5.0) for the MI trained group compared to 2.31 to 1.79 for the untrained group; percent MI Adherent scores increased from 37.96 to 64.86% adherent for MI trained group compared to 24.34 to 22.93% adherent for the untrained group. Other MITI indicators showed similar improvements that were mostly at, or just below recommended levels for beginning proficiency.

CHALLENGES AND RECOMMENDATIONS FOR CODING MI IN PROBATION

Our coders faced a number of challenges with respect to coding session tapes and interpreting scores. These difficulties most often resulted from the unique role that probation officers have, which balances helping and monitoring/enforcement tasks. Even though probation officers may be “change agents” in a broad sense, there are many individual tasks the officer must perform that are unrelated to motivating behavior change *per se*, including verifying probation progress, assessing risk, and delivering information and assistance. Because the MITI was originally designed to code single-behavior counseling interactions, our coders often had difficulty in three areas: 1) Coding and Interpreting Maintenance Tasks; 2) Accounting for Dual Roles; and 3) Identifying Target Behaviors. The sections below briefly describe the difficulties we encountered in each of these areas, and the approach we took to resolve the difficulties.

Table 1

Intraclass Correlation Coefficients in the Present Study and in Moyers, et al. (2005)

	Present Study	Moyers et al. (2005)
Global Ratings		
Empathy	0.492	0.518
MI Spirit	0.677	0.585
Behavior Counts		
Giving Information	0.499	0.758
MI Adherent	0.466	0.809
MI Non-adherent	0.560	0.750
Closed Questions	0.814	0.968
Open Questions	0.832	0.939
Simple Reflections	0.764	0.813
Complex Reflections	0.654	0.576

ISSN 2160-584X (online) Vol. 1 No. 1 (2012) DOI 10.5195/mitrip.2012.9

Coding and Interpreting Maintenance Tasks

One area of difficulty was the coding of maintenance tasks. Compared to other counseling interactions we have coded, our experience is that the probation system places many more clerical/documentation demands on probation officers. Some probation sessions are almost exclusively geared towards assessment tasks, while other sessions are partially geared toward assessment and partially geared toward behavior change. The difficulty we encountered was not the presence of such "housekeeping" tasks, but their sheer volume. In fact, the "directive" component of many sessions—the part the MITI was designed to code—often represented a minority of the session time. As one example, the probation system may require the office to ask a number of closed questions to verify current status and probation progress.

- *Any change in your residence?*
- *Any contact with the victim?*
- *Have you completed any community service hours since we last met?*

Officers may also use a number of simple reflections to verify that they have heard the probationer correctly.

- *So, you're still living at the same place.*
- *You have not had any contact whatsoever.*
- *You've attended a few times. Have you gone at least twice a week?*

In these cases, the purpose of the utterances is to verify rather than explore information, and thus closed questions and simple reflections may be adequate to the task. Closed questions were also sometimes used to obtain a simple yes/no response for documentation purposes. In some cases, a reflection (e.g., "You agreed to…") might be inadequate because it can be seen as putting words in a probationer's mouth, which can be insufficient for documentation. While these utterances are not difficult to code, and do not represent a violation of MI per se, the frequency of such utterances can make summary scores difficult to interpret. Likewise, in the case of simple reflections it can appear that the officer is not making much of an attempt to explore the client's perspective, when in fact, simple reflections have been used appropriately to make sure the officer understands the factual information the probationer has provided. The danger is that summary MITI scores may not adequately distinguish between officers who are using appropriate skills on MI-irrelevant tasks, and those who are performing badly on tasks where MI may be appropriate. In fact, the MITI was designed to rate counseling interactions focused on change in a target behavior, and thus some of the suggested competency thresholds for questions and reflections may not be reasonable for interactions that are more focused on assessment or verification tasks. While we were reluctant to disregard the thresholds entirely, we think that it is important to keep in mind the specific goals of the interview when providing feedback to officers. In fact, some probation interactions look very much like counseling interactions (where we might expect the MITI thresholds to apply), while others look much more like assessment interviews (where the MITI might be inappropriate).

One solution to this problem in our supervision sessions with the MI trained officers was to ask them to submit only tapes of meetings that were definitely focused on behavior change. (For the coding portion of the project described in this paper, we created cases that were specifically focused on probationers who were ambivalent about some area of behavior change.) This eliminated many interactions that were focused primarily on assessing or verifying progress, and many other (usually brief) interactions in which probationers were making good progress. Another strategy in our supervision sessions was to ask officers to conduct "housekeeping" tasks early in the session, so that MI coding could begin when the task shifted from verification of current information to talking about behavior change. This made it easier for coders to see the sections where MI would be relevant to the interaction. However, in practice, both of these strategies were difficult to achieve. Some officers preferred to move topically, verifying progress and then talking about change in one area, before moving to the next. So directive tasks (where MI may be appropriate) become more intertwined with housekeeping tasks (where MI may be irrelevant).

Another option for future coding studies like this might be to make changes to the MITI itself to accommodate interactions that contain more substantial maintenance components. As an example, one widely used system for coding doctor-patient interactions, the Roter Interaction Analysis System (RIAS; http://www.rias.org) contains many more categories for coding information-gathering tasks. (The RIAS captures 34 categories of physician communication, including tonal qualities and global affect.) While such coding systems lack the motivational features of the MITI, they would better capture some of the assessment and verification tasks that are expected of social workers, probation officers, and healthcare workers. The RIAS is organized around the four major sections of most medical visits—opening, history taking, exam, counseling, and closing, and it may be that MI strategies are more relevant during some sections than others.

In terms of the specific task, a hybrid version of the MITI might distinguish between closed questions that are intended to verify current information (e.g., "You've moved since we last spoke, right?"), check for understanding (e.g., "Did I get that right?"), or explore future behavior (e.g., "Are you going to start on your community service this week?"). Likewise, an information-giving category might distinguish between information that is intended to inform about what the officer will do (e.g., "I'll file this petition with the court on your behalf.") vs. what the probationer is expected to do ("When you get your copy in the mail, you will need to sign and return it."). Indeed, in the current system it is sometimes difficult to distinguish between utterances that are MI Non-adherent vs. those that are MI-irrelevant. This depends on the specific language and tone used, but also on the context of the utterance. Allowing for a range of categories within the MITI might provide a more accurate picture of the flow of the session, and help supervisors and researchers to understand how utterances contribute to the overall flow of the session.

Accounting for Dual Roles

Another area of difficulty was in determining how directions and information-giving contributed to the overall global ratings of the session. As discussed above, the global rating on Evocation can be considerably compromised when a substantial portion of the session is focused on asking questions to verify progress or giving (rather than eliciting) information. This interpretation is complicated by the inherent power difference and rigidity of some parts of the criminal justice interaction. In some ways, probation officers may have the flexibility to talk with a person about how/when they will complete requirements or emphasize the person's choice in completing requirements; but in other ways, a probation officer may have to be very rigid in terms of the specific requirements that have been dictated by the court.

As one example, in a traditional counseling interaction, the counselor may have much more flexibility to talk in terms of the client's stated interests or goals. For instance, moderate drinking may be a legitimate (however unwise) goal for clients who have chosen that outcome. But in a criminal justice context, moderate drinking is a more complicated topic if the court has mandated that the client remain abstinent. Although the officer can strongly support the client's right to choose to drink moderately, he/she must report any instances of drinking

ISSN 2160-584X (online) Vol. 1 No. 1 (2012) DOI 10.5195/mitrip.2012.9

to the supervising court. Likewise, the set of court mandates (and the officer's responsibility to monitor the probationer's progress) may also narrow the range of solutions that will be acceptable, for instance if a probationer wants to participate in outpatient treatment when the court has dictated inpatient treatment.

Because of the presence of court mandates, it was sometimes difficult for coders to determine how specific utterances contributed to the overall autonomy or evocation of the session. For instance, when a probation officer says that a client "needs to" attend AA meetings or "should" refrain from drinking it was sometimes unclear whether these utterances should be seen as providing information about court mandates or as MI Non-adherent confrontational statements. In fact, the areas in which our ICCs fell short in comparison to Moyers et al. (2005) tended to be concentrated around the issue of information giving and whether an utterance was MI Adherent or Non-adherent. In some instances, the tone of the utterance or very small differences in phraseology provided the only clues as to how it should be coded. Consider the following probation officer utterances, where the probationer has been court mandated to attend AA:

- *You have a problem and need to attend AA.* (MI Non-adherent; confront, direct)
- *As part of your probation, you'll need to attend AA.* (Probably MI Non-adherent; direct)
- *If you want to avoid problems with your probation, you'll need to attend AA.* (Probably *not* MI Non-adherent; action contingent on desire)
- *Your court conditions state that you need to attend AA. What do you want to do about that?* (*not* MI Non-adherent; does not dictate an action)

The first two statements would probably be coded as MI Non-adherent (and reflect negatively on autonomy) because they seem to suggest that the probationer does not have a choice—the probationer *must* attend AA. The second two statements would probably be coded as giving information (and be seen as autonomy-neutral), because they suggest that an action is conditional on the desire of the client—*if* the probationer wants to be successful. There were many statements like the second and third that fell into the "gray" range; although we developed rules around coding such utterances, it was still very difficult to reach agreement when coding independently.

Another difficult situation was when probationers reported behavior that violated their probation conditions. In such situations, it is generally not an option for the officer to leave such reports unaddressed. The officer must report illicit behavior to the court and must inform the probationer that he/she will do so.

> Probationer: *I just used a little bit of weed to take the edge off. But I'm done with that.*
>
> Officer: *We talked earlier on about my dual role…both to you and the court. Because of that, I will need to report that to the court, and if there are any further instances of drug use, you will likely be looking at a jail sanction.*

Outside of a criminal justice context, such an exchange might be coded as an MI Non-adherent confrontational statement, because it seems to dictate a course of action for the probationer; however in this context, the officer has been true to his/her duties as an agent of the court. In this instance, we would be more likely to code such an exchange as giving information because the officer has informed the probationer about what the officer must do and what might happen if future drug use is discovered, while at the same time not prescribing a course of action for the probationer.

Finally, we encountered many miscellaneous instances of information-giving during more extensive assessment interviews.

> *You'll need to have a valid form of identification to get into the program. If you don't have a license, you can get one from the Department of Motor Vehicles.*

According to the MITI manual, such unsolicited information might be seen as lack of power sharing and thus might decrease the global rating for Collaboration. However, in this instance, the officer might have been trying to help the probationer understand and interpret the court requirements, which involved, in this case, obtaining an identification card. Again, the difficulty was not their presence, but the overall volume of such informational/teaching statements, compared to longer counseling sessions. For our coding project, we asked coders to consider the transaction as a whole and decide whether the officer was restating and interpreting the court conditions to make sure the probationer was aware of them (autonomy neutral) or using court conditions to lessen the probationer's perception of control (autonomy diminishing).

Determining a Target Behavior

Because probation officers must often focus on several target behaviors, in some instances it was difficult to determine global ratings for Collaboration and Direction. Successful collaboration requires mutual problem solving and planning between the officer and the probationer to remedy a target behavior. However, when there are multiple behaviors being addressed, as there are frequently in a probation setting, problem solving and planning can prove to be more difficult for the officer as he/she is having to change direction, or focus, on the behavior at hand.

> Officer: *So you were drinking when you hit your wife?*
>
> Offender: *I drink every day, and sometimes she says things that make me angry.*

In this example, the officer has identified three potential target behaviors—substance abuse, spousal abuse, and anger management---each of which may warrant a different conversation, and only some of which may be related to probation requirements per se. It is not always clear which behavior warrants more attention as they all need to be addressed at some point in the interview. Thus, it is difficult to isolate the true target behavior in the session.

In our study, we asked coders to consider the gestalt of the session, and interpret the target behavior broadly as making positive steps on behaviors that would increase success on probation conditions. In some instances, this included multiple behaviors that might be related to probation success.

RECOMMENDATIONS FOR USE OF THE MITI FOR TRAINING AND PRACTICE IN PROBATION

Although we did encounter some difficulties in coding the language of probation sessions, the results of the parent study show that the MITI was a reliable instrument and that the MI-trained group did increase their mean MITI ratings when compared to the untrained group. This suggests that probation officers can be taught to use MI skills in their interactions with probationers, at least during relatively controlled role-play conditions. Nonetheless, in addition to the more global tone of the session, there were a number of specific behaviors that frequently occurred that caused officers to be rated more poorly even when it appeared that the officer was trying to engage or support the client.

ISSN 2160-584X (online) Vol. 1 No. 1 (2012) DOI 10.5195/mitrip.2012.9

In some cases, there was a clear violation of the MI style indicators, as evidenced by harsh, confrontational statements (e.g., "What did you expect the cops to do? You were found with the knife!") or copious advice giving (e.g., "Why don't you try talking to your wife about it? You've got to share this with her."). However, the more common difficulties had to do with instructions about future behavior or clarifications of probation conditions that were coded as confrontational statements or unsolicited advice because of the way the utterance was stated.

For instance, our coders agreed that the following statements were likely to be coded as MI Non-adherent even when the probation officer assumed a neutral tone of voice and generally positive spirit. All were judged to be directive per the MITI manual.

1. *You did very well last semester. I want you to apply yourself to school that same way.*
2. *I need you to fill out your monthly report form today.*
3. *Call and let me know how your job interview goes.*
4. *Don't forget to call.*
5. *Behave this weekend, but have fun.*

Officers who were able to communicate such information in an MI adherent way most often used strategies such as *removing the first person pronouns* from their utterances, *asking questions rather than telling* what to do, and *deferring to court requirements* or policy. For instance, our coders agreed that the following statements conveyed very similar information, while generally steering clear of MI Non-adherent (directive) language.

1. *You did very well last semester. What are some of the things you could do to keep your grades up?*
2. *Would you please fill out your monthly report today?*
3. *I would love to hear how your job interview goes. Would you mind calling to let me know how it goes?*
4. *Just a reminder that the deadline for registration is approaching, so if you want to get enrolled in the class, you'll need to call this week.*
5. *I hope you have a fun, safe time this weekend. (*Or, *What are some things you could do to stay safe this weekend?)*

CONCLUSION

This paper described some of the challenges of using the MITI to code criminal justice interactions and some of the ways we resolved these difficulties. While we did not make changes to the MITI instrument itself, the rules of thumb we describe above may help to identify the strengths and weaknesses of the MITI in coding criminal justice interactions. Importantly, we found the MITI was already a useful and reliable coding instrument in most areas. Rather, the challenges of MITI coding most often resulted from the unique tasks of probation officers.

As a result of our coding experiences, we have made a series of changes to our officer trainings. Part of our training now focuses on the overall MI spirit indicators, as evidenced by probation officers' attentive, respectful attitude. Open questions and reflections are often indicators of such an interest and respect. Another part of the training involves an attention to phraseology to help officers bring some statements more in line with the technical aspects of MI that are likely to be captured on the MITI utterance ratios. Reviewing session tapes often involves an explanation of why a statement—though well intentioned—would be coded as MI Non-adherent, as well as brainstorming alternative ways of communicating such information. We hope that this balance of style and content will help officers not only to exhibit the spirit of MI, but also to be able to perform well on MI rating instruments. Most importantly, we are hopeful that these small changes in our training curriculum will improve the communication between officers and clients, and contribute to a more positive and helpful experience for clients on probation.

REFERENCES

Bennett, G. A., Moore, J., Vaughan, T., Rouse, L., GibbinS, J. A., Thomas, P., et al. (2007). Strengthening Motivational Interviewing skills following initial training: A randomised trial of workplace-based reflective practice. *Addictive Behaviors, 32*, 2963-2975.

Bennett, G. A., Roberts, H. A., Vaughan, T. E., Gibbins, J. A., & Rouse, L. (2007). Evaluating a method of assessing competence in Motivational Interviewing: A study using simulated patients in the United Kingdom. *Addictive Behaviors, 32*, 69-79.

Bennett, G. A., Roberts, H. A., Vaughan, T. E., Gibbins, J. A., & Rouse, L. (2007). Evaluating a method of assessing competence in Motivational Interviewing: A study using simulated patients in the United Kingdom. *Addictive Behaviors, 32*, 69-79.

Boardman, T., Catley, D., Grobe, J. E., Little, T. D., & Ahluwalia, J. S. (2006). Using motivational interviewing with smokers: Do therapist behaviors relate to engagement and therapeutic alliance? *Journal of Substance Abuse Treatment, 31*, 329-339.

Cicchetti, D. V. (1994). Guidelines, criteria, and rules of thumb for evaluating normal and standardized assessment instruments in psychology. *Psychological Assessment, 6*, 284–290.

Madson, M. B., & Campbell, T. C. (2006). Measures of fidelity in motivational enhancement: A systematic review. *Journal of Substance Abuse Treatment, 31*, 67-73.

Moyers, T. B., Martin, T., Manuel, J. K., Hendrickson, S. M., & Miller, W. R. (2005). Assessing competence in the use of motivational interviewing. *Journal of Substance Abuse Treatment, 28*, 19-26.

Moyers, T. B., Martin, T., Manuel, J. K., Miller, W. R., & Ernst, D. (2009). Revised global scales: Motivational interviewing treatment integrity 3.1 (MITI 3.1). Retrieved from http://casaa.unm.edu/download/miti3_1.pdf

Moyers, T. B., Miller, W. R., & Hendrickson, S. M. L. (2005). How does Motivational Interviewing work? Therapist interpersonal skill as a predictor of client behavior within Motivational Interviewing sessions. *Journal of Consulting and Clinical Psychology, 73*, 590-598.

Pierson, H. M., Hayes, S. C., Gifford, E. V., Roget, N., Padilla, M., Bissett, R., et al. (2007). An examination of the Motivational Interviewing Treatment Integrity code. *Journal of Substance Abuse Treatment, 32*, 11-17.

Shrout, P. E., & Fleiss, J. L. (1979). Intraclass correlations: Uses in assessing rater reliability. *Psychological Bulletin, 86*, 420-428.

Thyrian, J. R., Freyer-Adam, J., Hannover, W., Roske, K., Mentzel, F., Kufeld, C., et al. (2007). Adherence to the principles of Motivational Interviewing, clients' characteristics and behavior outcome in a smoking cessation and relapse prevention trial in women postpartum. *Addictive Behaviors, 32*, 2297-2303.

Tollison, S. J., Lee, C. M., Neighbors, C., Neil, T. A., Olson, N. D., & Larimer, M. E. (2008). Questions and reflections: The use of motivational interviewing microskills in a peer-led brief alcohol intervention for college students. *Behavior Therapy, 39*, 183-194.

ISSN 2160-584X (online) Vol. 1 No. 1 (2012) DOI 10.5195/mitrip.2012.9

Walters, S. T., Vader, A. M., Nguyen, N. D., Harris, T. R., & Eells, J. (2010). Motivational interviewing as a supervision strategy in probation: A andomized effectiveness trial. *Journal of Offender Rehabilitation, 24*(11), 309-323.

ISSN 2160-584X (online) Vol. 1 No. 1 (2012) DOI 10.5195/mitrip.2012.9

Motivational Interviewing MITRIP
TRAINING · RESEARCH · IMPLEMENTATION · PRACTICE

Equipoise and Equanimity in Motivational Interviewing

William R. Miller, PhD[1]

Abstract

The spirit of MI bespeaks a kind of equanimity as a general characteristic of MI practice. This desirable counselor quality is quite distinct from the conscious choice of counselor aspiration: whether to strategically move toward a particular change target, or to intentionally maintain neutrality with regard to change goal (the latter being referred to as equipoise). Both choices would involve equanimity, and both require intentional, conscious and skillful attention to the interpersonal dynamics of change talk that have been elucidated through the development of and research on MI.

Keywords

decisional balance, equanimity, equipoise, neutrality

I will begin by confessing that I had forgotten I was to give one of the papers in this symposium. I thought I had only agreed to be the discussant. So, I went back to the hotel room last night and wrote the opening talk. These are simply some thoughts with much help from Steve Rollnick about this particular situation where you either don't have an opinion or you want to be sure that you don't exert influence on the process of a person moving one way or another. I've distinguished equipoise from equanimity—the latter being a kind of balance or presence that we would like to have as a part of the spirit of motivational interviewing no matter what we're doing. To avoid strong advocacy and exerting your expertness and so forth is just a characteristic of MI spirit—to keep that kind of general balance. With equipoise, though, we're really talking about a particular situation that has to do with counselor aspiration and the question, "Should I proceed to strategically favor the resolution of ambivalence in one particular direction?" I'm saying that equipoise involves making a conscious decision of whether you want to do that or not. "Should I try to maintain a neutrality about this and carefully not tip the balance in one direction or another?" And I'm going to encourage very much that you be aware of which way you're going, and to make a conscious decision whether you are trying to steer in a particular direction or you're trying to avoid doing so. I further maintain that what we have learned about motivational interviewing is important here and helps us know to proceed. MI was originally developed for the former situation where you have the intention of resolving ambivalence in a particular direction.

So here are a few scenarios where you're faced with a client and you have to make that choice:

- One that I used in the 1983 article is a person coming to try to get some help in deciding whether to have children. Now that, in my mind, very clearly is something that I should stay out of. It is not my business to tip the balance one way or the other, but it would be very possible if you're not aware of what you're doing to inadvertently favor going down one route without even realizing it, and that is exactly the scenario in my original paper.
- What about an adolescent who's considering whether to use condoms when having sex? Well, I'm a little more swayed by that one. So what decision will I make here? Am I steering in that direction or not?
- How about a man who is injecting speedballs into his veins, injecting combinations of heroin and methamphetamine, a very dangerous practice. Now I'm pretty clear on this one. Particularly if I work in an addiction treatment center, I'm wanting and expected to steer him in one particular direction.
- What about a drunk driver? Now here is someone who affects not only him or herself, but is endangering other people as well, and just on behalf of the social welfare I'm feeling inclined to not be in equipoise here.
- What about a soldier, someone in the military, who, for whatever reason, is playing Russian roulette in his spare time, spinning the barrel of the gun and pointing it to his head? Well, I'm getting more urgent about my decision.
- What about a sex offender who's contemplating new victims?

So here we have a whole range of clinical situations, ranging from some where I clearly think, "No, I really want *not* to be influencing the person's direction of choice" to other situations where I am inclined very much to be steering the person in one particular direction.

I especially like something that Terri Moyers has offered us, which is "the waitress test." Terri says, "I want you to imagine a waitress who works on her feet ten hours a day, works very hard for the money she earns. She pays taxes on her earnings, and part of the taxes that she pays support my salary to be sitting in this chair and talking to this client. Would it make sense to her, would she be okay with my not having an opinion and not moving in any particular direction in these various situations?" I think there are some where clearly she would not be too happy with me just sitting there and not steering in one direction or another. It's a kind of common-sense equipoise question.

[1] University of New Mexico

A version of this paper was presented in the symposium *MI in Equipoise: Oxymoron or New Frontier?,* Second International Conference on Motivational Interviewing (ICMI), Stockholm, Sweden, June, 2010.

The author reports no conflicts of interest.

Correspondence concerning this article should be directed to William R. Miller, PhD. Email: wrmiller@unm.edu

ISSN 2160-584X (online) Vol. 1 No. 1 (2012) DOI 10.5195/mitrip.2012.10

Within the model that Steve and I talked about this morning this comes up in the second process of focusing, where you identify a change goal. I would maintain, in fact, that the term "equipoise" doesn't make any sense until you know a change goal, because it's equipoise *about* something. So we have to have a particular scenario and then decide whether we're in equipoise about a particular goal, and it should be a conscious choice. "I'm willing to pursue aspirations of moving the person in a certain direction," or "I'm going to try to carefully not to tip their balance in one direction or the other." If we go down the aspiration route then we're into the latter two processes that Steve and I spoke about: evoking and planning. But what if you choose to go down the other route? What do you do then? Both of these choices involve equanimity. Both of them involve that kind of balanced way of being that we talk about as MI spirit. Both involve a collaborative approach. Both of them recognize that ultimately it is the other person who makes this decision, so it's not any different with regard to spirit.

One thing that we know very clearly is that if you cause people to argue for a particular position on a consequential issue, one that matters to them, without any obvious coercion or heavyhanded influence, they are likely to move in that direction. That was the work of Leon Festinger with cognitive dissonance and of Daryl Bem in developing self perception theory. That was what Bob Cialdini (2007) described in *Influence*, a human tendency toward consistency with what we say, and it's what we're finding in MI process research, that you can evoke change talk and when you do that people tend to move in the direction of doing it, as long as they don't feel coerced or unduly influenced. If you hold a gun to their head and say, "Tell me you're going to change." they don't internalize that, but when the arguments emerge without there being any obvious coercion to do it, it becomes a self-fulfilling prophecy. So I would maintain that understanding the psycholinguistics of choice is very relevant for keeping your balance in equipoise. If you want to avoid moving a person in one direction, then you should avoid differentially listening to and reinforcing change talk on one side of the argument, either consciously or inadvertently.

Now that is very different from client-centered theory and therapy. In client-centered counseling you wouldn't worry about these things. You wouldn't really be strategically pursuing goals, nor would you be strategically avoiding it. Truax (1966) did publish an article maintaining that Carl Rogers differentially reinforced certain kinds of client statements even though he was unaware of it and denied that he was doing it. Truax analyzed transcripts of Rogers' counseling and found that he was responding differentially, conditionally, and I think it's quite possible to do that without being aware of it. The psycholinguistics of motivation suggest that there are particular things to do to avoid this when what you choose is equipoise.

So how can you keep your balance? How do you not accidentally or unknowingly favor one direction or another? To me equipoise is exactly the situation where a classic decisional balance is the thing to do. You consciously give balanced attention to the pros and cons in listening, in what you ask about and where you ask for elaboration, in what you affirm, what you reflect and what you include in your summaries. All of the things that are directional within motivation interviewing become two sided, double sided when you're doing a decisional balance, when your intention is equipoise. Decisional balance is an ideal tool to remember and use when you want to keep your balance and not inadvertently steer a person in a particular direction.

So is that motivational interviewing? It is certainly informed by MI research on change talk. If we didn't know what we know about motivational interviewing, we wouldn't know how to do this and wouldn't even be worried about it. It does involve skillful guiding to explore both sides equally. Thus there's still conscious intention and direction to it in that sense of working to keep your balance. You are surely using engaging skills in listening to both sides of the dilemma—not just one side, but both sides of the dilemma. So it sounds a lot like motivational interviewing. It's also clearly different from client-centered counseling. Yet Steve and I are provisionally persuaded that the answer to that question is "No." It's not uniquely motivational interviewing until there is a change goal and you're strategically moving toward it.

My final point, however, is that it doesn't really matter whether it's called MI or not, because the question is "What's the right thing to do when you're in one of these situations and you want to be sure to maintain equipoise? What's the best thing to do?" That to me is what matters much more than whether it is regarded as inside or outside the tent of motivational interviewing.

REFERENCES

Cialdini, R. B. (2007). *Influence: The psychology of persuasion*. New York: Collins Business.

Truax, C. B. (1966). Reinforcement and non-reinforcement in Rogerian psychotherapy. *Journal of Abnormal Psychology, 71*, 1-9.

ISSN 2160-584X (online) Vol. 1 No. 1 (2012) DOI 10.5195/mitrip.2012.10

Motivational Interviewing
TRAINING · RESEARCH · IMPLEMENTATION · PRACTICE
MITRIP

Splitting Hairs or Parsing Concepts, Fuzzy Thinking or Fuzzy Categories

Where Does Motivational Interviewing End and Client-centered Therapy Begin?

David B. Rosengren, PhD[1]

Abstract

An increasingly robust debate is emerging about the role of equanimity, equipoise and equality of concepts in defining what constitutes motivational interviewing (MI) versus client-centered therapy. At the heart of this debate is whether a MI practitioner may remain neutral about a goal and still be practicing MI. After that point of agreement, the debate becomes increasingly complex and defuse. However, MI has never included in its definition that the clinician identifies a specific behavioral goal. Nor is this articulated in any of the principles. Instead, it seems to be an ad hoc explanation of what does and does not constitute MI practice in an effort to establish the boundaries of MI. It is clear that a lack of data and only a nascent theory of how MI works contribute to this problem, but it may also be issues of fuzzy thinking and fuzzy categories. An exploration of these areas suggests it is possible that a practitioner could be practicing MI and not have a specific behavioral goal, other than assisting the client in resolving ambivalence.

Keywords

motivational interviewing, client-centered therapy, definitions, fuzzy logic

In quarters interested in motivational interviewing (MI), there has been considerable discussion and debate about what constitutes MI. This debate has centered on the idea of equipoise, with the primary issue defined as whether a practitioner may remain neutral about a goal and still be practicing MI. Bill Miller has argued that without a target goal, there is not MI; my fellow panelists and I have taken a different stance and hence this panel was born.

Let's begin with a couple of important points. First, Allan Zuckoff asked the panelists to address the question, "Motivational Interviewing (MI) in Equipoise: Oxymoron or new frontier?" as the basis for these talks. Acting like any good politician, I chose to answer not the question I was asked to address, but instead the one I wished to answer. The title of this paper contains that preferred question, "Where does MI end and client-centered counseling begin?", which suggests that to decipher this issue of equipoise, there is further sorting of definitional issues needed within MI.

To understand these definitional issues, we need to understand how MI evolved and thus begin with a brief (and casual) historical review. The seeds of MI began with Bill Miller's dissertation. At the conclusion of this alcohol treatment trial, he randomly assigned participants to go home with a self-help book or not. Those who received the book continued to show improvement, while those who did not remained at posttreatment levels (Miller, 1978). Being the curious sort, Bill wanted to figure out what lay under this process, so he designed a follow-up study where people received either treatment or a self-help manual and to his "horror" (Miller, 1994), discovered that people in the manual only condition did just as well as those receiving active treatment (Miller, Gribskov, & Mortell, 1981). Two subsequent studies produced the same outcomes (Miller & Taylor, 1980; Miller, Taylor, & West, 1980). A trial with untreated controls showed the changes weren't a function of just being assessed (Harris & Miller, 1990). This process led to interactions with a group of thoughtful and inquisitive psychologists in Norway (where he began to specify his reasoning for particular techniques) and a 1983 article that introduced the concepts of MI (Miller, 1983).

What follows is a slow building of initial interest, a collaboration with Steve Rollnick that produced the seminal text on MI (Miller & Rollnick, 1991) and its first revision (Miller & Rollnick, 2002), and an explosion of publications and research interest over two decades. During this process, research and data-driven decision making created the precepts of MI. It wasn't until 2009 (Miller & Rose, 2009) that the first article describing an underlying theory of MI appeared. During these two and a half decades, practitioners and researchers extended MI well beyond its application in alcohol and drug use disorders to areas as diverse as health care, preventive care, homelessness, criminal justice, education and spiritual care and with varying degrees of success (Lundahl, Kunz, Brownell, Tollefson, & Burke, 2010; Hettema, Steele, & Miller, 2005). As we extended MI beyond its original borders, we also made it more difficult to find where the boundaries of MI lie. Steve Rollnick refers to this issue as asking, "Where do the tent pegs go?"

This is a visually rich metaphor, which implies a finite line to which the definition (and perhaps intervention) can be stretched. This MI method, borne of unexpected findings and research experience rather than theoretical derivations, and based on the traditions of client

[1] Prevention Research Institute, Lexington, KY

Dr. Rosengren is also affiliated with the Alcohol and Drug Abuse Institute, University of Washington.

A version of this paper was presented in the symposium *MI in Equipoise: Oxymoron or New Frontier?,* Second International Conference on Motivational Interviewing (ICMI), Stockholm, Sweden, June, 2010.

The author has no conflicts of interest to disclose.

Correspondence concerning this article should be directed to David B. Rosengren, PhD, Prevention Research Institute, Inc., 841 Corporate Drive, Suite 300, Lexington, KY 40503. Email: drosengren@askpri.org

ISSN 2160-584X (online) Vol. 1 No. 1 (2012) DOI 10.5195/mitrip.2012.11

centered therapy, perhaps predictably marched to the underlying question about equipoise, “Where does MI end and client-centered therapy begin?”

To answer that question, it’s appropriate to begin with the current definition of MI. In the second edition of Motivational Interviewing (Miller & Rollnick, 2002), the official definition was, “MI is a client-centered, directive method for enhancing intrinsic motivation to change by exploring and resolving ambivalence (p. 25).” On the listserv of MINT, the sponsor of this journal, members have discussed and debated an evolving form of definition that included the following: “MI is a person-centered, guiding method of communication to elicit and strengthen motivation for change.” As they look towards the third edition of their MI text, Miller and Rollnick shared at ICMI-II the possibility of having multiple levels of definition depending on the needs of the user, with the degree of specificity linked to the need of the user. This approach is intriguing, though still in flux. Interestingly, missing from these definitions is an explicit statement that the client must identify a specific goal (and a statement of what an appropriate goal would be).

Client-centered therapy (later referred to as person-centered; Rogers, 1961) also has some definitional challenges. While the six necessary and sufficient conditions are well known (i.e., relationship, client vulnerability to anxiety, therapist genuineness, unconditional positive regard and accurate empathy and the client's perception of the therapist's genuineness) (Prochaska & Norcross, 2007; Rogers, 1957), its definition is more elusive. Rogers (1961) described this approach in the first person: “If I can provide a certain kind of relationship, the other person will discover within himself the capacity to use that relationship for growth, and change and personal development will occur (p. 33).” Implicit in this definition is the central concept of self-actualization—the internal drive towards growth that client-centered therapists free in the process of this therapy. While a bit fuzzy, these definitions of MI and client-centered therapy make sense from each intervention’s perspective and they look distinct—until we start looking at the specifics.

The trouble with definitions lies in their details. As Walter Lang noted, “A creationist can embarrass an evolutionist by asking for a definition of species” (Lang, 2011). While the vast majority of scientists would agree there’s far more research support for evolution that creation, when we get to the issue of definitions the creationist can hold sway by virtue of the murkiness of the waters and not the support of the data. There’s another problem with definitions, as noted by Flaubert: “As a rule we disbelieve all the facts and theories for which we have no use” (Flaubert, 2011). Within psychology, we describe this phenomenon in terms of confirmatory biases. We tend to discount things that don’t agree with our views and selectively attend to things that support our views; the result is we attend to the information or data that confirms our views and discredits the others. I wonder if this is the case in this debate. As we grapple for clear definitions, are we finding it easier to poke holes in the arguments of those who disagree with our viewpoint then to find the place where the tent pegs should go? Do we then reinforce our positions by selectively attending to the data that supports our positions and discounts others’ views?

Then there was equipoise, which was the reason for this panel, and brings us back to definitions (or at least the trouble with definitions). Chris Dunn (Dunn, 2009) noted that equipoise appears to refer to two states: counselor’s demeanor and counselor behavior. The former refers to counselor poise, balance and patience, while the latter describes the therapist’s aspiration and activity with regards to a specific goal. In Bill’s response to Chris, he opined, “Never thought about it in relationship to general demeanor. It’s always been in relationship to specific behavior.” Indeed, Bill went on to clarify in his address at this conference that the first is equanimity and the second equipoise, and while an MI therapist should have equanimity, the intervention is no longer MI if there is equipoise; that is, the therapy must have a directive element. While we agree on the importance of equanimity, it seems we disagree on what MI must be directed towards. For Bill, it is towards a specific goal, while for the remaining panelists it is much broader—resolution of ambivalence or deciding if there is something that warrants attention.

Perhaps there is now greater clarity on equanimity and equipoise, yet we still haven’t precisely defined what MI is and where the boundaries are. Or have we misconstrued the issue? Do we need more hard thinking or a whole different way of thinking about the issue? Perhaps the issue is not fuzzy thinking, but rather fuzzy categories. More specifically, the issue may lie in how we think about the nature of definitions.

The traditional definition of MI originates in Boolean logic (2011), which (typically) involves a binary system. In this approach, a value either is or isn’t something. It’s one or a zero, a yes or a no, MI or not MI. Fuzzy logic (2011) approaches this problem differently. Fuzzy logic stems from fuzzy set theory and multi value logic, where something has a degree of a quality. It’s not all or nothing, but rather a degree from 0 to 1, where zero is none of the quality and one is all aspects. In this system you can have a .97 or a .63. This logic specifies to what degree an entity (e.g., a therapy session) matches the characteristics you’ve specified. This approach would suggest the degree of “MI-ness” observed.

There is an example of a fuzzy logic system in general use among mental health practitioners: DSM-IV-TR (American Psychiatric Association, 2000). Not all symptoms are necessary for major depression, posttraumatic stress disorder, or alcohol dependence disorder to be diagnosed. Instead, the person requires only a certain number of symptoms to receive a diagnosis. In some cases, symptoms must originate within certain categories. Strength, above a certain threshold, can vary for these criteria. Applying this to MI then, it may be possible to think of MI as having dimensions, along which practitioners will vary, including one that extends from equipoise to directionality. Given this conceptualization, it is both possible and consistent with MI orthodoxy that a practitioner could exemplify the two components of MI (spirit and techniques), specifically elicit and reinforce change and remain explicitly neutral about the outcome other than assisting the client in resolving ambivalence.

This idea became even more intriguing as Bill Miller and Steve Rollnick laid out the conceptual framework for the third edition of *Motivational Interviewing* in an earlier ICMI-II talk. One area that was particularly interesting is the suggestion of four processes of MI, of which three are necessary for MI and the fourth may not be. (I will leave the specification of these processes to those authors in their time.) They noted several definitions under each of the first three processes and commented that perhaps there’s a degree to which one has each of those different processes. Most importantly, it’s not necessary to have them all in the same or equal amounts in order for something to be MI. It would seem that MI may be switching its underlying logic and this question may become moot.

And so then we circle back to equipoise and ask a different question: Why does this matter? Well, for many practitioners it probably doesn’t. They move in and out of equipoise frequently with regards to doing clinical work. The nature of problem behavior and their role will define when directionality or equipoise becomes salient. The goal for MI as a field may be to help these practitioners to be more conscious of their decision-making in this process, while the practitioner simply wants assistance in doing what will be most helpful for clients.

For other situations, greater specificity does matter. Development and evaluation of MI as an evidence-based practice (EBP) (Hartzler, Beadnell, Rosengren, Dunn, & Baer, 2010) relies on the capacity to define and differentiate MI practice. To test it versus other therapies or to

ISSN 2160-584X (online) Vol. 1 No. 1 (2012) DOI 10.5195/mitrip.2012.11

identify essential elements within it, researchers must be able to define what is and is not MI. The same holds true for evaluations of training effectiveness and implementation fidelity more generally. Without clear definitions there is a risk for Type III errors, where what the researcher thinks is being measured (intervention) and what is actually being measured (implementation) are different. This knowledge is also critical for MI trainers as they need to know what to train, how to assess training needs and training methods, and what is necessary for competent and expert practice. It is also critical for the development of the underlying theory of MI.

REFERENCES

Boolean Logic (2011). Wikipedia [On-line]. Available: http://en.wikipedia.org/wiki/Boolean_logic

Fuzzy Logic (2011). Wikipedia [On-line]. Available: http://en.wikipedia.org/wiki/Fuzzy_Logic

American Psychiatric Association (2000). *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition Text Revision* (DSM IV-TR). (Fourth ed.) Washington D.C.: American Psychiatric Association.

Dunn, C. (2009). MI and Client-Centered Counseling. IAMIT-L . Ref Type: Internet Communication

Flaubert, G. (2011). Confirmatory biases. Brainy Quotes [On-line]. Available: http://www.brainyquote.com/quotes/authors/g/gustave_flaubert.html

Harris, K. B. & Miller, W. R. (1990). Behavioral self-control training for problem drinkers: Components of efficacy. *Psychology of Addictive Behaviors, 4,* 82-90.

Hartzler, B., Beadnell, B., Rosengren, D. B., Dunn, C., & Baer, J. S. (2010). Deconstructing proficiency in motivational interviewing: Mechanics of skilful practitioner delivery during brief simulated encounters. *Behavioural & Cognitive Psychotherapy, 38,* 611-628.

Hettema, J., Steele, J., & Miller, W. R. (2005). Motivational interviewing. *Annual Review of Clinical Psychology, 1,* 91-111.

Lang, W. (2011). Creationism. Brainy Quotes [On-line]. Available: http://www.brainyquote.com/quotes/authors/w/walter_lang.html

Lundahl, B. W., Kunz, C., Brownell, C., Tollefson, D., & Burke, B. L. (2010). A meta-analysis of motivational interviewing: Twenty-five years of empirical studies. *Research on Social Work Practice, 20,* 137-160.

Miller, W. R. (1978). Behavioral treatment of problem drinkers - Comparative outcome study of 3 controlled drinking therapies. *Journal of Consulting and Clinical Psychology, 46,* 74-86.

Miller, W. R. (1983). Motivational interviewing with problem drinkers. *Behavioural Psychotherapy, 11,* 147-172.

Miller, W. R. (1994). Notes from the desert. *Motivational Interviewing Newsletter for Trainers, 1,* 4-6.

Miller, W. R., Gribskov, C. J., & Mortell, R. L. (1981). Effectiveness of a self-control manual for problem drinkers with and without therapist contact. *International Journal of the Addictions, 16,* 1247-1254.

Miller, W. R. & Taylor, C. A. (1980). Relative effectiveness of bibliotherapy, individual and group self-control training in the treatment of problem drinkers. *Addictive Behaviors, 5,* 13-24.

Miller, W. R., Taylor, C. A., & West, J. C. (1980). Focused versus broad-spectrum behavior-therapy for problem drinkers. *Journal of Consulting and Clinical Psychology, 48,* 590-601.

Miller, W. R. & Rollnick, S. (1991). *Motivational interviewing: Preparing people to change addictive behavior.* New York: Guilford Press.

Miller, W. R. & Rollnick, S. (2002). *Motivational interviewing. Preparing people for change* (2 ed.). New York: Guilford Press.

Miller, W. R. & Rose, G. S. (2009). Toward a theory of motivational interviewing. *American Psychologist, 64,* 527-537.

Prochaska, J. O. & Norcross, J. C. (2007). Systems of psychotherapy: A transtheoretical analysis (6th ed.). Belmont, CA: Thompson Brooks/Cole.

Rogers, C. R. (1957). The necessary and sufficient conditions of therapeutic personality change. *Journal of Consulting Psychology, 21,* 95-103.

Rogers, C. R. (1961). *On becoming a person.* Boston, MA: Houghton Mifflin.

ISSN 2160-584X (online) Vol. 1 No. 1 (2012) DOI 10.5195/mitrip.2012.11

Motivational Interviewing
TRAINING · RESEARCH · IMPLEMENTATION · PRACTICE
MITRIP

Client-centered Direction

Or How to Get There When You're Not Sure Where You're Going

Christopher C. Wagner, PhD[1]

Abstract

Change is broader than behavior, and often starts before a goal or plan is conceived, with clients first opening up to the vague possibility of betterness. Collaboration is a hallmark of MI spirit, and therapeutic direction can be developed collaboratively in MI through the process of evoking client values, desires, needs, hopes, and goals. Counselors may initially aspire to help clients find better lives, and narrow the focus to discrete change goals when specific client behaviors are collaboratively identified as obstacles to achieving a better life, or when absence of behaviors is identified as inhibiting progress toward it.

Keywords

motivational interviewing, client-centered, direction, collaboration, provider aspiration, therapeutic focus

Various descriptions of motivational interviewing suggest that a tension exists between the client-centered and directional aspects of the approach. That tension is sometimes duplicated in discussions about these two aspects, with those who are more focused on the client-centered aspect being concerned about MI becoming manipulative if it is too directive and those focused on the directional aspect being concerned about MI becoming ineffective if it is too client-centered.

What I'd like to do is turn attention away from such concerns and map out some ideas that I think represent a middle-ground.

DIRECTION IN CLIENT-CENTERED THERAPY AND MOTIVATIONAL INTERVIEWING

Rogerian therapy is client-centered because it prioritizes clients' experience, perception and preferences over practitioners' or society's perceptions and preferences. Rogerian client-centered therapy is also held to be non-directive, and in many ways it is. Practitioners typically don't offer direct advice or attempt to influence the client to make specific choices, engage in specific actions or pursue specific outcomes. At the same time, Rogers' own theory provided some general directions to pursue, including helping clients free themselves from self-imposed judgments and internalized societal restrictions, as once freed of these constraints, clients could more effectively pursue their real selves and a more autonomous life. And it seems pretty clear that Rogers selectively focused on these elements in exploring clients' perspectives in his work, some of which was documented in a study of selective reinforcement in Rogerian therapy (Truax, 1966). While Rogers' approach may lack specific behavioral outcome goals, there is a fairly clear general direction toward deepening and broadening client experience and perception.

Over time, the concepts of client-centeredness and non-directiveness seemed to become somewhat conflated, and a significant contribution of motivational interviewing when it was introduced was to once again separate these concepts and, somewhat boldly, pair client-centeredness with direction.

Direction was developed in early descriptions of MI through the exploration of discrepancy between client behaviors and preferred goals or values, and through elicitation of "self-motivating statements." Categories of self-motivating statements included recognition of disadvantages of the status quo and advantages of change, and development of optimism for change and intention to change. In the 2002 MI book revision (Miller & Rollnick, 2002), self-motivating statements were renamed "change talk," although retaining the subtitle "self-motivating speech" and the four categories. By 2004, with publication of the Amrhein categories now familiar as DARN-C (Amrhein et al, 2003), the overt reference to client self-motivation in descriptions of MI seemed to become more peripheral, and the focus seemed to gradually shift more toward reinforcing client language than eliciting client intrinsic motivation, at least to my eyes.

One apparent outgrowth of this shift in focus has been to allow the source of direction in MI to increasingly be seen as emanating from the practitioner, who guides the client toward a particular goal and reinforces client interest in that direction. A secondary consequence of the shift in focus has been the emergence of the idea that an interaction may not truly be MI unless the practitioner has a specific outcome goal in mind that he or she is influencing the client toward. This idea that a specific behavior change goal is required seems to be based on the belief that if

[1] Departments of Rehabilitation Counseling, Psychology and Psychiatry, School of Allied Health Professions, Virginia Commonwealth University

A version of this paper was presented in the symposium *MI in Equipoise: Oxymoron or New Frontier?,* Second International Conference on Motivational Interviewing (ICMI), Stockholm, Sweden, June, 2010.

Thanks to the MINT Network for collaboratively developing these ideas, particularly Karen Ingersoll for the idea that MI strategies have direction "built in" and Janis Crawford for the idea of a pathway that focuses on therapeutic processes before progressing to a focus on client outcomes.

The author has no financial interest related to the publication of this article.

Correspondence concerning this article should be directed to Christopher C. Wagner, PhD. Email: chriscwagner@gmail.com

ISSN 2160-584X (online) Vol. 1 No. 1 (2012) DOI 10.5195/mitrip.2012.22

the practitioner doesn't have a specific outcome in mind, he or she can't know which parts of a client's ambivalence to reinforce, and thus can only do non-directive client-centered therapeutic work. The concept seems to have become more or less binary—either there is a specific change goal that provides direction, or there is no specific change goal and thus no direction.

I want to be clear that this is my impression of some of the discussions on the MI trainers listserv and in MI forums and conferences, not Miller & Rollnick's publications, which have not yet taken up such considerations, as far as I'm aware, other than the section in the MI -2 book entitled "When motivational interviewing is non-directive," which suggests that selective reinforcement toward specific outcome goals is not necessary for the interaction to be considered MI. It's a different argument than I'm making here, but it also contradicts the stance that practitioners must be working toward a specific outcome in order for the work to be considered MI.

So, from my perspective, an either/or way of viewing MI is unnecessary. Of course I think MI can be done with a specific change goal in mind. However, I don't think a specific change goal is necessary for the work to be directional or to be considered MI.

CLIENT-CENTERED DIRECTION

One conceptualization of motivation is that it involves direction, effort and persistence (Arnold et al, 2010). Direction is only one of three components in this definition, and there is no requirement that it precede the others in the process of developing motivation. Direction might point the way, but effort is what establishes momentum, and persistence determines how far the change is carried (in time as well as in magnitude of outcome).

Imagine a journey taken by airplane. In getting started, persistence is not important initially; you're just taking off—persistence will determine how far you go but is less relevant to getting started. However, direction is not particularly important initially either. Taking off from an airport does not require flying in the direction of your final destination. At most airports, planes all take off in the same direction, regardless of their destination. They first establish *momentum* for takeoff and later adjust the direction toward an eventual goal after the journey is underway.

I think that motivational interviewing can work that way too. We don't have to know where we are going in order to get started; what's important first is establishing momentum. Momentum often starts before a specific end goal is established. Having clear goals can certainly positively influence effort and persistence. However, there is also evidence that the process of setting those goals is an important part of their influence on motivation, and that influence can be negated if the person perceives goals to be imposed rather than chosen (Arnold, 2010). Requiring practitioners to have a pre-established goal in order to conduct motivational interviewing seems to me to be an unnecessary limitation on the practice of MI that potentially limits its effectiveness, and worse, may backfire and become an obstacle to promoting successful client change.

Collaboration is a hallmark of the spirit of MI. Direction can be developed collaboratively by evoking clients' values, desires, needs, hopes and goals. And direction is "built-in" to MI strategies and process regardless of whether a specific behavior change is identified at the outset or along the way. Counselors can initially aspire to help clients find better lives, then gradually narrow the focus to discrete change goals when specific behaviors are collaboratively identified as either supports or obstacles to achieving a better life.

The figure below shows a narrowing path from initial engagement through moving into action. I think it fits well with the emerging conceptualization of MI as engaging, focusing, evoking and planning (Miller & Rollnick, 2010).

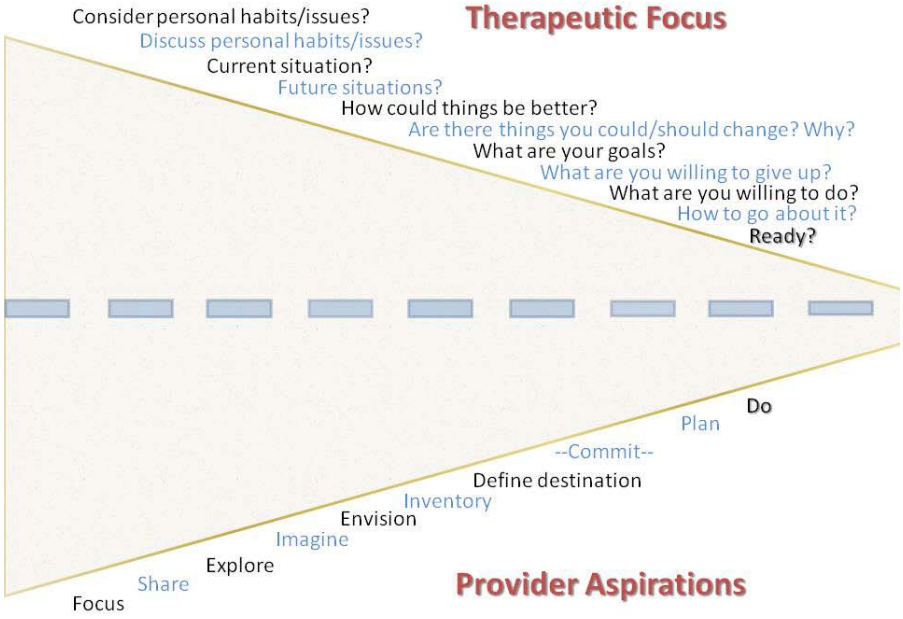

Figure 1

Narrowing Focus in MI

ISSN 2160-584X (online) Vol. 1 No. 1 (2012) DOI 10.5195/mitrip.2012.22

The top of the graphic shows the therapeutic focus, beginning with broad engagement strategies of asking clients to consider and discuss their personal life—habits, lifestyle, concerns and interests. The focus begins to narrow somewhat to reviewing current and possible future situations that are related to the goal of reaching a better life. As the work proceeds, the practitioner evokes client thoughts about how things could be better, what changes might be made and why the client would want to make them. Narrowing even further, the practitioner helps the client plan changes by eliciting the client's goals, having the client identify what he or she is willing to do toward those goals (as well as what the client will stop doing if certain habits are obstacles to achieving those goals), and helping the client plan specifically how he or she will go about achieving the now-defined goal. Finally, of course, the focus turns to initiating the developed change plan.

An important point about conceptualizing MI in this way is that the momentary therapeutic focus is defined collaboratively, not in a fixed way. If a client has already thought through his or her lifestyle and defined how things could be better, the practitioner simply joins the client at that point on the pathway to change (perhaps briefly reviewing the earlier elements to "catch up" to where the client is). There is no need to drag a client back to the beginning as might be specified in a structured treatment manual that focuses more on practitioner behaviors than client perspectives.

A secondary point is that in this conceptualization, the practitioner does not need to predefine a specific behavior change target or goal in order to do the work of MI. Progress toward change is reinforced at whatever degree of specificity makes sense given the client's current position along the pathway. A better life, improved health, less stress, or abstinence from alcohol—any breadth and specificity of definition of a change goal is fine. Narrowing directional focus is part of the process that can be pursued from whatever point the client is at in the present. Practitioners do not need to predefine a change goal and then work toward eliciting the client's agreement with it; change goals are developed collaboratively between the two as a result of focused exploration (assuming the client has not come with goals already identified).

Along the bottom of the graphic are provider aspirations that also have direction "built-in" but that are process aspirations rather than aspirations for specific client behavior changes. These process aspirations also narrow over the course of working together, from wanting the client to focus, share and explore, to wanting the client to imagine future possibilities, envision a more specific future to pursue, and take steps toward pursuing it, including considering specific change possibilities, defining an end destination, committing to pursuing it, planning the change and then carrying out the plan.

I don't think this is a particularly radical reinvisioning of MI, but just an attempt to clarify my perspective that a well-defined behavior change goal is not needed before proceeding to use MI with clients, or for the work to have direction. While practitioners may take a position of equipoise in regard to specific client choices and goals, direction can still be established through practitioner exploration of client interests in change, however broadly or vaguely defined they may initially be—and motivational interviewing inherently promotes directional change through the processes of engaging, focusing, evoking and planning and associated tasks, by gradually narrowing and refining therapeutic focus.

REFERENCES

Amrhein, P. C., Miller, W. R., Yahne, C. E., Palmer, M., & Fulcher, L. (2003). Client commitment language during motivational interviewing predicts drug use outcomes. *Journal of Consulting and Clinical Psychology, 71,* 862-878.

Arnold, J. & Randall, R. (2010). *Work psychology: Understanding human behaviour in the workplace.* (5th edition). Harlow, Essex: Pearson Education.

Miller, W.R. & Rollnick, S. (2002). *Motivational interviewing: Preparing people for change* (2nd ed.). New York: Guilford Press.

Miller, W.R. & Rollnick, S. (2010, June). What's new since MI-2? Presented at the Second International Conference on Motivational Interviewing, Stockholm, Sweden.

Truax, C.B. (1966). Reinforcement and non-reinforcement in Rogerian therapy. *Journal of Abnormal Psychology, 71*, 1-9.

ISSN 2160-584X (online) Vol. 1 No. 1 (2012) DOI 10.5195/mitrip.2012.22

Motivational Interviewing MITRIP
TRAINING · RESEARCH · IMPLEMENTATION · PRACTICE

Research on MI in Equipoise

The Case of Living Organ Donation

Allan Zuckoff, PhD[1], Mary Amanda Dew, PhD[1,2]

Abstract

Residual ambivalence prior to live organ donation has been shown to predict worse physical and psychological outcomes for the donor following surgery. We are studying whether MI can help individuals who have agreed to become living organ donors to resolve residual ambivalence about their decision. In this situation, ethical practice demands that the counselor take up a stance of equipoise, equally welcoming of strengthened resolve to donate or a decision not to do so. This paper describes our adaptations of MI for this unique application.

Keywords

motivational interviewing, equipoise, organ donation

The question raised by this symposium is whether or not motivational interviewing done from a position of equipoise is, in fact, MI. Well, my colleagues and I are embarked right now on a study in which we are doing, or so we believe, MI in equipoise. My intention in this paper, then, is to describe the context in which we are working, as well as the intervention we have developed, and ask you to consider this question: Are we, in fact, doing MI in equipoise?

THE CONTEXT OF THE INTERVENTION

Living Organ Donation

Living organ donation involves donation of a kidney, most typically, or more infrequently a part of the liver, to someone else who needs it. The impetus for the development of living organ donation several decades ago was the fact that there weren't enough deceased donor organs to go around; more people needed transplants than could be provided by people who had died. As it turns out, the outcomes from living organ donation are generally superior to those from deceased donor organs; people who receive a kidney or liver segment from a living donor survive longer after the transplant, are less likely to have rejected the organs, and more likely to have a high quality of life.

But this procedure has raised a concern in the medical profession because it is a unique medical situation: the person donating the organ is undergoing major surgery, which has obvious risks no matter how well it's done. The donor is healthy and can receive no possible medical benefit from it, yet may potentially be harmed by it. The medical profession, of course, operates from the principle, "First, do no harm." So within the profession the question has repeatedly been raised: should living donation even be permitted, given that it may do harm to someone who is not otherwise at risk?

The answer to this question that has allowed living organ donation to continue is that the surgical risk to donors has become low (particularly for kidney donors), and most donors report positive outcomes from having been a donor. In the case of donors who are related to their recipients, the perceived costs of not being able to donate and knowing that the recipient will not survive may much higher than those associated with surgery. Dew and colleagues (2007) reported that more than 95% say that they would donate again if they were in the same situation, and 72% report positive feelings about themselves as a result of their donation. So there is a benefit received, though it is not a medical one: it is the benefit of feeling better about who they are. People who have donated often say that it is the most meaningful thing they've ever done in their lives, knowing that they have given the gift of life to someone else. And in general they do not appear to suffer any harm: when asked about their perceptions of their physical functioning, their psychological well-being, and their social well-being, they report average levels equivalent to the general population or better.

So it appears that donors, as a group, are not suffering and are reporting benefits from having done so. However, a minority of donors do report negative outcomes: 24% across multiple studies report significant psychological distress in the aftermath of their donations, 12% report that their health is worse, and 25% worry about their health in the present and future (after all, if you've given up a kidney, you have only one kidney left), and 23% report financial distress.

Given that a minority of living donors does report negative outcomes, the profession has begun to ask, What can we do to predict who is likely to experience those negative outcomes? And, once we can predict those outcomes, how do we prevent them—don't we have an

[1] Departments of Psychology and Psychiatry, University of Pittsburgh [2] Departments of Psychiatry, Epidemiology, Biostatistics, Surgery and Medicine, University of Pittsburgh School of Medicine and Medical Center

A version of this paper was presented in the symposium *MI in Equipoise: Oxymoron or New Frontier?,* Second International Conference on Motivational Interviewing (ICMI), Stockholm, Sweden, June, 2010.

This research was supported by Grant R21 NR011149 (Dew) from the National Institute of Nursing Research, Bethesda, MD.

The authors have no conflicts of interest to report.

Correspondence concerning this article should be directed to: Allan Zuckoff, PhD, Department of Psychology, University of Pittsburgh, 210 S. Bouquet Street, Pittsburgh, PA, 15260. Email: zuckoffa@pitt.edu

ISSN 2160-584X (online) Vol. 1 No. 1 (2012) DOI 10.5195/mitrip.2012.12

obligation to do what we can for these generous people to prevent them from suffering from their generosity?

To understand the negative outcomes it's important to think about how a person actually makes the decision to donate an organ. As the pioneering researcher Roberta Simmons (Simmons, Marine, & Simmons, 1987) described, this is a major, high-stakes life decision. It is irreversible: once you've donated an organ, you cannot go back. The outcome of the decision is not assured; the person to whom you donate may not live, and their body may reject the organ; your medical safety is likely, but not guaranteed. It affects the donor's most central relationships: if I'm donating to a family member or loved one I'm giving something to that person that that person can never reciprocate, but if I choose not to donate that obviously affects the relationship as well; my decision also affects the other people in my family to whom I'm not donating, since I am now potentially medically compromised. It's a decision made in crisis, and there is often little time to make it. It is a decision of a type that is unfamiliar, for which there are no clear norms. And of course it is an altruistic decision: I gain nothing from doing this other than whatever I gain from helping someone else.

The Donor's Ambivalence

And so it shouldn't be surprising, as Simmons also pointed out, if we find a fair amount of pre-donation ambivalence in people who are making the decision about donating an organ. There is fear of the surgery itself, fear of the recovery period (the pain, but also the financial effects of being unable to work for a period of time and of being unable to meet family obligations to children or spouse), and worry about the long-term health effects. There may be family pressure involved in making a decision like this: it could be an overt demand—the family comes to one of its members and says, You should donate your organ so your father or brother or sister or a child can live—but it may be a more subtle or indirect pressure, as when someone says, I'm going to die if I don't get an organ donated to me and nobody has stepped forward yet. Sometimes there's a perception that I'm obligated to donate, that my family would want me to do this whether or not I would want to. And there's also the phenomenon of "black sheep" donors, people who donate because they are alienated from their family and hope that if they do this thing, their family will finally forgive them and they will finally get the love that they were looking for. And finally, there may also be ambivalence around the recipient: not just the question of whether this person will live, so that my sacrifice will be meaningful, but also, How do I feel about the recipient taking this gift from me? Donors often have questions about what the recipient is going to do with this gift, and may have concerns about how they will feel if the recipient doesn't treat the gift with the specialness the donor thinks they ought to.

Interestingly, Simmons and colleagues' (1987) research showed that for a large proportion of donors none of these factors played any role. The choice was instantaneous and there was no deliberation: people say things like, I didn't think about it; as soon as I knew the person needed it I knew I was going to donate. On the other hand, for others there is a process of deliberation: collecting relevant information, identifying and evaluating the pros and cons of donating, and finally making and implementing a decision. And there's a small group who actually seem to postpone the decision all together, who never feel as though they made a decision even though they are on track toward donating an organ. And what they say is that they started on that journey and they never exactly decided to do it but the process just sort of carried them along, and at some point they felt like that they had to go through with it even though they themselves never really decided if this is what they wanted to do.

So a significant number of living donors report pre-donation ambivalence, and Simmons went beyond describing this ambivalence: she developed a reliable way to measure it. The Simmons Ambivalence Scale (SAS) is comprised of seven items, rated on a scale from 0-3:

- How hard a decision was it for you to donate?
- Did you know right away that you would do it or did you think it over?
- Many donors have doubts and worries going into transplant operation, even though they go through with it. Did you ever have doubts about donating?
- How would you have felt if you found out that you couldn't donate for some reason?
- How strongly do you agree or disagree with the statement "I sometimes feel unsure of not donating."?
- How strongly do you agree or disagree with the statement "I sometimes wish the transplant patient would get a cadaver organ instead of one from me."?
- How strongly do you agree of disagree with the statement "I would really want to donate myself even if someone else could do it."?

It turns out that the answers to these seven questions, which when given after the donor has agreed to donate assess what we have come to refer to as *residual ambivalence*—ambivalence after having agreed to donate that coexists with the donor's intention to donate—is the only consistent predictor of risk for poor psychosocial outcomes after donation. The variables one might expect to predict negative reactions to donation—from demographics to psychological distress to type of surgery to outcome for the recipient—are not informative.

Now acute ambivalence—ambivalence before the development of any clear intention to donate—rules people out of donation. Someone who is that uncertain about whether or not they want to continue down the path toward donation surgery is disqualified for their own protection. The people we are discussing intend to donate yet they have continuing uncertainty co-existing with that intention. Simmons and colleagues (1977) first identified a correlation between pre-donation ambivalence in 130 pre-surgery kidney donors and negative attitudes about donation one year after the surgery (r = .31, p = .001). Switzer, Simmons, and Dew (1996) found in a sample of 343 anonymous bone marrow donors that residual ambivalence was common (positive SAS items > 0 in 62%, positive SAS items≥ 5 in 12%) and that residual ambivalence alone predicted physical difficulty with donation and negative psychological reactions post-surgery and at one year post-donation (controlling for post-surgery reactions) in 251 of these donors who were able to be assessed at follow-up.

THE INTERVENTION

On the basis of these findings, Dew was inspired to seek to develop a pre-surgery intervention that could prevent negative outcomes by resolving residual ambivalence in living donors. This led her to motivational interviewing and to a collaboration with Zuckoff in order to develop and test such an intervention.

And this is an application of MI that, we hold, absolutely requires equipoise in the counselor as he or she enters the encounter with the client. It must be equally acceptable to the counselor that the potential donor (PD) either recommits to donating and becomes certain that is what he or she wants to do or decides not to donate. Any intent on the counselor's part to tip the client one way or the other would clearly be unethical. Instead, the outcome we are seeking is a reduction in ambivalence, regardless of the direction in which the ambivalence is resolved.

We developed a two-session intervention provided over the telephone in sessions of 30-45 minutes each. The sessions take place

ISSN 2160-584X (online) Vol. 1 No. 1 (2012) DOI 10.5195/mitrip.2012.12

after the PD has been medically and psychologically cleared to donate following extensive evaluation. Session 1 begins with structuring that emphasizes confidentiality (i.e., that neither the recipient, the family, nor the transplant team will have access to any of what is discussed and that the conversations will have no impact on whether or not the PD will be permitted to donate), the goal of helping the PD feel at peace or more settled with the decision (whatever that decision is), and the PD's personal choice and control. The counselor asks about the story of the decision to donate, how the PD came to be at this place, and we listen for, reflect and explore desire, ability, reasons, and need for donating (change talk) as well as for not donating (sustain talk). The results of the SAS are used to provide feedback, exploring any of the items that the person endorsed. And the session ends with a planning process, which may involve concrete problem-solving for what needs to happen next for the PD to address his or her lingering doubts or concerns, or a more cognitive process of how to shift perspectives and come to terms with the decision the PD has made.

But what's critical from the standpoint of equipoise is that there are three pathways through the session. If it emerges that the PD has truly *residual* ambivalence—that is, the PD wants to donate, intends to donate, believes it's right for him or her, but has lingering doubts or fears and thus feels unsettled—then the counselor steps out of equipoise and does motivational interviewing as it is normally done, helping the PD move toward a full commitment to the decision he or she has already made and wishes to carry out. On the other hand, if it emerges that the PD is leaning away from donating, or has had a change of heart, then the counselor will do motivational interviewing to help the PD move toward full commitment not to donate, to carry out his or her preferred decision and feel settled and at peace with it. And if the PD were to show *acute* ambivalence, being genuinely uncertain, then the counselor would maintain equipoise and do a decisional balance discussion, as described in "When Motivational Interviewing Is Non-directive" in the second edition of *Motivational interviewing* (Miller & Rollnick, 2002), exploring both sides of the ambivalence without trying to tip the balance one way or the other.

In session 2 the counselor reviews the plan and any progress that's been made. The plan may have been a residual ambivalence plan for the PD to get the information needed to feel less anxious or more settled—for example, plans have included the PD speaking with the surgeon about unanswered questions, talking with a family member about a lingering concern, or talking to somebody who's been through donation to reduce the sense of going into the unknown. In contrast, a change of heart plan might focus on how the PD will take the steps necessary to get off the donation path that he or she is on. Whatever the plan was, the counselor invites the PD to discuss how the plan went, whether or in what ways it worked, and helps the PD revise the plan if needed. The counselor then guides the PD through a values card sort (having mailed the cards to the PD prior to the session), with the intent to evoke and explore the PD's core values and how a decision to donate or not to donate fits with those values. The session ends with further planning for what the PD will do in the immediate and post-surgery future, a look ahead to where the PD hopes to be with in the aftermath of whatever decision he or she has made, and affirmation of the PD's courage in carrying out that decision.

LOOKING FORWARD

At the time of this writing our research team, having completed a small number of intervention development cases, is conducting a randomized controlled pilot study comparing the two phone sessions of MI with either two sessions of healthy lifestyle education by telephone or with "usual care" provided by the Living Donor Transplant Program (no telephone sessions of any kind). We will be following up participants at six weeks, three months, and six months to see whether MI does differentially reduce ambivalence on the SAS, and reduce the frequency of negative outcomes. But my question to you now, on the basis of what I have just described, is: MI in equipoise—oxymoron or new frontier?

REFERENCES

Dew, M.A., Switzer, G.E., DiMartini, A.F., Myaskovsky, L., & Crowley-Matoka, M. (2007). Psychosocial aspects of living organ donation. In H.P. Tan, A. Marcos, & R. Shapiro (eds.), *Living donor transplantation.* New York: Informa Healthcare USA, Inc.

Miller, W.R. & Rollnick, S. (2002). *Motivational interviewing: Preparing people for change* (2nd ed.). New York: Guilford.

Simmons, R.G., Marine, S.K., & Simmons, R.L. (1987). *Gift of life: The effect of organ transplantation on individual, family, and societal dynamics.* New Brunswick, NJ: Transaction, Inc.

Switzer, G.E., Simmons, R.G., & Dew, M.A. (1996). Helping unrelated strangers: Physical and psychological reactions to the bone marrow donation process among anonymous donors. *Journal of Applied Social Psychology, 26,* 469-490.

ISSN 2160-584X (online) Vol. 1 No. 1 (2012) DOI 10.5195/mitrip.2012.12

Motivational Interviewing
TRAINING · RESEARCH · IMPLEMENTATION · PRACTICE
MITRIP

Comments on "MI in Equipoise: Oxymoron or New Frontier?"

William R. Miller, PhD[1]

So I have an answer to the title question as to whether equipoise is an oxymoron or a new frontier. The answer is, "Yes."

Well isn't this just wonderful, this discussion today. One thing I'm thinking to myself as I sit here is, "Why are we even worried about whether this should be called MI or not?" I guess there are two reasons that Steve and I have tossed around. The first is just for clarity in explaining to people what MI is and how it's different from other things that they're familiar with. The other reason is to not try to claim too much for MI, to say, "If you're doing reflective listing then you're doing MI" and thereby try to subsume the work of Rogers and other people by calling it MI. So those are two things we've worried about.

I love David's DSM suggestion. We've got four processes, and is any one of them essential in order to make it MI? If you have any *two* of them is it MI? I don't think even two will do it for me. To me it seems that it's not MI yet until you get to evoking. What Chris seems to be saying is that if there is engaging and focusing, these two, then you're comfortable that this is MI. Engaging and planning are both things that a cognitive behavior therapist might often do. How many of these do you have to have in order to make it MI, and does it have to be particular ones? It's an interesting question.

The thing that strikes me most of all as a new frontier in this is thinking about a science of equipoise. First of all it implies being *conscious* of your decision about whether you are or are not trying to steer in a particular direction. I suspect this is something that often clinicians don't even think that much about—considering whether I am (or should be) steering or not steering in a particular direction. I think it's quite important to consider this because clearly you *can* steer a person in one direction or another. If this is so, and you decide that you *don't* want to steer the person in one direction or another, then what should you do clinically? That's a very good question, and I think another challenge here is one that Allan raises: If you want to avoid steering, how do you know if you've done it right? That's a good question in itself. I mean, the criterion can't be that the person fails to reach a decision. That's not necessarily a good outcome. So you would hope perhaps that they make a decision and are no longer ambivalent about the choice they've made. A good example of this is the work that Allan has done in regard to organ donation. What this calls us to do is to be conscious of aspirations and to do different things depending upon whether we're consciously trying to move in one direction or not. I think that's a relatively new discussion. People have certainly talked about therapists inadvertently moving clients to our own views about things, but how do you *not* do that? I think this is something that's relatively innovative.

Chris used "direction" in a broader way than I have yet to use it, and we can get confused by meaning different things with the same word. Obviously there's a lot of direction to what Allan is talking about doing here. There's a goal to it, which is to resolve the ambivalence. There's a systematic way of going about it, to know where you're going and what you're trying to do, so it's not directionless wandering around in a client-centered wilderness. There's a real systematic nature to it, an intention, and I think that's important. We will have a chapter in MI-3 on counseling with equipoise because there are so many implications for MI and it just has to be there.

And then the other thing that occurs to me is that what we're dealing with in the passion around this issue is discomfort with the very idea that we would influence the decision of another person to go in a particular direction—a discomfort that we *can* do that (which I think is really clear) and that we *would* be doing that. And these worries are increased, I think, if we're doing this and a person isn't aware that we're doing it.

Now that is not a problem for salespeople. Salespeople *want* to do that; they want to influence your decision and may not particularly care if you know how they're doing it. They have a desired outcome in mind and strategies for getting there. This is also not something that people in corrections wrestle with much—whether they should influence an offender's decision to offend or not. I mean you just don't worry about that very much in corrections. There is a direction to move in. I think the fact that I came out of the addiction field is a piece of this, too, because we don't fret a good deal about whether we should help somebody stop injecting speedballs. It's a clearer kind of situation. It's when you get into less clear terrain that psychotherapists may start getting itchy and uncomfortable about whether it is okay to influence someone else's choice, and whether there is something fundamentally wrong about doing that. I think it can stick in the craw of psychotherapists who wrestle with it, but plainly for me it is *possible* to influence the choice and decision of another person. In sales and in business that's done all the time, and it is clear that therapists do that, too, aware of it or not. That being so, what this calls us to do, I think, is to be aware and intentional and systematic about how we behave in this situation of equipoise.

[1] University of New Mexico

A version of these comments was presented in the symposium *MI in Equipoise: Oxymoron or New Frontier?,* Second International Conference on Motivational Interviewing (ICMI), Stockholm, Sweden, June, 2010.

The author reports no conflicts of interest.

Correspondence concerning this article should be directed to William R. Miller, PhD. Email: wrmiller@unm.edu

ISSN 2160-584X (online) Vol. 1 No. 1 (2012) DOI 10.5195/mitrip.2012.19

Motivational Interviewing
TRAINING · RESEARCH · IMPLEMENTATION · PRACTICE
MITRIP

Motivational Interviewing in a Residential Treatment Programme

Colin O'Driscoll, MSc[1]

Abstract

An Irish entrepreneur and motivational interviewing specialist created a residential treatment programme for addictions in Ireland with motivational interviewing not only as the model for therapy but also as the guiding spirit for the treatment environment and repertoire of activities. This article describes the treatment programme, characterises those served by it, and presents results of a preliminary assessment of treatment outcomes. The article concludes with consideration of the challenges and successes of this unique residential programme.

Keywords

motivational interviewing, residential treatment, evidence based practice

The present article reviews the creation of Forest Treatment Centre, a motivational interviewing (MI) treatment programme in a residential context. The article details its birth through specific interactions and encounters, its establishment through programme design, and its development through treatment integrity.

THE BEGINNING

An Irish entrepreneur was lucky enough to come across Tom Barth, Norwegian psychologist, whilst researching addiction treatment options and approaches. He was excited by both the man he encountered and the approach that he was learning about. He was determined to bring MI to Ireland, and for the approach to be available in a residential context. He saw this as a positive addition to the more common traditional treatment centres, which tended to be either hospital-based or faith-based and to share the Minnesota Model as their approach.

The vision was to embrace the MI approach from top to bottom and start to finish. He therefore wanted every aspect of the service to reflect the ethos of the model itself. Forest was to be an evidence-based residential treatment centre exclusively utilising the model of motivational interviewing, with its robust empirical support, in four forums:

- One-to-one therapy with psychologists (trained in MI)
- Group therapy with psychologists (trained in MI and the transtheoretical model)
- Holistic activities (e.g., yoga, mindfulness, Aikido therapy, massage)
- Environmental therapy (all aspects of the environment intended to reflect the ethos of MI, through staff MI training)

They started by picking a location, and building and recruiting a team, that would help to realise his vision. The actual centre chosen was a guest house in the Wicklow mountains, the garden of Ireland. Befitting this location, those who come to Forest are referred to not as patients, or even as clients, but as guests. The environment is completely open (no locked doors or gates), and guests are free leave the programme at any point in time. Guests are not searched upon arrival; they are trusted to make good decisions and the responsibility to do so is not taken from them. Guests are permitted to use mobile phones, reading materials, computers, etc. In fact, the only real rule that may be imposed is that they abstain from alcohol or non-prescribed drugs throughout their stay—a limitation that is more about protection of the environment (respect for others and safety of staff) than about any judgment of guests' decisions.

The environment of the centre was to reflect the spirit of MI. The goal is for the guest to always be made to feel welcome. All staff (from domestic to treatment) were to be trained in the basic skills of MI. Emphasis was placed on warmth and empathy and treating those who came to Forest for help in changing processes of addiction as autonomous adults, in an atmosphere of absolute dignity and respect.

THE TREATMENT PROCESS

Enquiry and Assessment

Guests who enquire about Forest are greeted warmly and respectfully. They are informed of their options. No commitments are imposed. The decision to take an assessment is made available.

During the assessment, a psychologist enquires by way of a standard clinical interview as to what the individual would like help with, engaging the guest in an MI style conversation, with the aspiration of increasing readiness for change. This is also an opportunity for the psychologist to explain about the programme and answer any questions that the guest may have. At the conclusion of this conversation, if both are agreed about the necessity and appropriateness of treatment, a place on the programme is offered.

Assessment begins at this interview but is considered continuous during guests' stays. Assessment tools used include the URICA (University of Rhode Island Change Assessment), Socrates (Stages of Change Readiness and Treatment Eagerness Scale), DRINC (Drinker Inventory of Consequences), BDI (Beck Depression Inventory), and HAS (Hamilton Anxiety Scale).

[1] Forest Treatment Centre, County Wicklow, Ireland

Correspondence concerning this article should be addressed to Colin O'Driscoll, MSc. Email: colin@changepsychologyservices.com

Editor's Note: Since acceptance of this article, economic conditions in Ireland forced closure of Forest Treatment Centre.

ISSN 2160-584X (online) Vol. 1 No. 1 (2012) DOI 10.5195/mitrip.2012.13

	Mon, Wed & Fri	Tues & Thurs	Sat & Sun
09:30	Group Review	Group Review	Group Review
10:30-13:00	1 hour 1:1 therapy	2 hour Yoga	Aikido (Sat) Hiking (Sun)
13:00-14:00	Lunch	Lunch	Lunch
14:00-17:00	1 ½ hour group therapy	Mindfulness (Tues) Art Therapy (Thurs)	Visiting
17:00	Group Review	Group Review	Group Review
19:00	Evening Meal	Evening Meal	Evening Meal
20:30	Meditation	Meditation	Meditation
	Scheduled Massage		

Figure 1

Typical guest schedule

Admission

Guests arriving at Forest are greeted by both care workers (staff with basic training in healthcare who are employed to organise the.environment for guests and provide support where necessary) and the administration team. They are shown around the house, offered tea, introduced to the team and their fellow guests and shown to their room, where they can settle and orientate before meeting the nurse and doctor for formal admission.

The Programme

The following morning the guest has breakfast and then meets with the project worker, who outlines the programme for that day (which will include a one-to-one therapy session, group therapy session and meditation). On non-therapy days (in between therapy days) guests engage in a range of holistic activities. A typical schedule is outlined in Figure 1.

Having awoken, shared breakfast and attended a morning review, on therapy days guests attend their one-to-one therapy session. They are met with a respectful and non-judgemental therapist who will present as a collaborator in the shared role of supporting a change. The therapeutic goal initially is about developing a strong alliance. As phase 1 of their treatment (the "whys" of change) progresses, exploration of ambivalence and level of change is the primary objective.

By session 6 at the end of their 2nd week, guests are invited to write a summary of their therapeutic experience. In this session they share their summary and a "milestone summary" prepared by the therapist is then read and presented to them. This report centres on strengthening commitment (summarising guests' concerns, summarising ambivalence, providing evidence of change talk, and subjective and objective assessments of guests' situation). This report is written to the guest (in "you" language), and is followed up with MI key questions, again geared towards strengthening commitment. Guests are then presented with a change plan to fill in. From session 7 on guests are in phase 2 (the "how's" of change).

The group therapy component of the programme follows the same phased structure as the individual therapy; in phase 1 the emphasis is on developing alliance and working with ambivalence about change, and in phase 2 the focus shifts to the "hows" of change. The transtheoretical model (TTM) understanding of the processes of change informs the content of the group sessions, including the teaching of standard relapse management strategies arising out of the relapse piece in the stages of change.

The repertoire of holistic activities is supplied by individually registered and qualified individuals in their respective fields. The specific activities were selected on three terms. Firstly, activities that embrace general health and well being were regarded as essential. Secondly, activities that are likely to develop self-efficacy were prioritised. Thirdly, activities that demonstrate an independent evidence base in this treatment area were considered to be optimal, for example, hiking (adventure therapy), mindfulness, and art therapy.

As previously stated, all staff are trained in basic skills of MI. Therefore, in addition to structured MI individual and group therapy sessions, all conversations in the environment are expected to be conducted in a generally MI adherent manner, and policies and procedures for staff reflect this.

Throughout their stay, each guest's care plan is continually monitored, and the tailoring of the programme to their specific needs is always prioritised. Continuation with the programme occurs only on the basis of guests' fully collaborative involvement; engagement in the programme is for them to choose on an on-going basis.

The performance of treatment programme staff is also monitored on an ongoing basis. Fidelity to MI in both individual and group therapy sessions is monitored using the Motivational Interviewing Treatment Integrity (MITI) coding tool in addition to dedicated MI supervision.

GUEST PROFILE AND PATHWAYS TO ADMISSION

The most common guest presents with problems relating to alcohol dependence and abuse. The female population is marginally greater than 50%. The second most common guest presents with problems associated with substance misuse and dependence (most commonly prescription, or over the counter, followed by illicit). The remaining guests (about one quarter of the total) present with process addictions (e.g., gambling, internet, sex) and various presentations of stress and depression.

Guests who come to Forest do so through a variety of pathways. Private health insurance is the norm for Forest, and indeed the norm for Ireland (65% of population). Some guests pay privately, although this is very much the minority and mainly overseas guests from the USA or Europe. There are some public treatment options, meaning that some of

ISSN 2160-584X (online) Vol. 1 No. 1 (2012) DOI 10.5195/mitrip.2012.13

the guests are referred through inner-city (Dublin) drug task forces for either respite care or intensive therapeutic week stays (intensive MI in the context of coming off the last dose of methadone).

It is worth noting that although the exclusion criteria include severe and acute mental health problems (e.g. acute psychosis) and requirement for extended detoxification, more than 95% of all who present for assessment are deemed to be appropriate. The most common reason for a place not being offered by the assessing professional is judgment that an extensive detoxification process (e.g. from benzodiazepines) is required.

MEASUREMENT OF TREATMENT EFFECTS

Programme retention and completion is tracked by Forest staff. Baselines are established at the beginning of treatment in a number of outcome areas, and guest outcomes are assessed at discharge and 3 month, 6 month, and 12 month follow-up. In addition, an independent psychologist conducted an outcome analysis which involved a mixed-method design using a specifically designed survey to interview by telephone all past guests of Forest between three months and three years post discharge. Thirty seven percent of the target sample (n = 69) took part in the survey interview; 60% of the sample could not be contacted and 3% refused to participate.

Treatment Outcomes

As both the theory of MI and research on its effects on treatment engagement and adherence would lead us to predict, guests at Forest tend to come in, make good decisions for themselves, stay in treatment, and engage fully. Retention among all who begin the programme and consequently complete the programme is above 95%.

Analysis of change between baseline and follow-up points is not currently available. Results of the survey interview analysis showed that:

- Over 4 out of 5 rated their progress between 75-100%;
- 61% changed exactly in accordance with the change plan they left the programme with;
- 70% of those with a goal of abstinence felt that they had achieved (or are achieving) that goal;
- <8% felt that they had not achieved that goal;
- 93% would recommend Forest as a treatment option to others;
- 86% reported that their quality of life had improved since treatment at Forest;
- 97% reported that they would, if they could go back in time, choose again to seek treatment at Forest.

Research Limitations

The 37% response rate is relatively low and a higher response rate and/or sample target size may have yielded more complete and reliable data. It is reasonable to assume that a higher portion of poor outcomes would be found among the 63% who refused participation. Analysis of data from the 3, 6 and 12 month follow-up assessments would provide a fuller picture of the Centre's outcomes.

CHALLENGES AND SUCCESSES

Forest as a residential treatment centre does not fit into the standard frameworks for addressing these diagnostic groups (for instance alcohol dependence, substance misuse). It is neither a hospital, nor a public health outreach centre. It is not psychiatrically led and therefore the public health system has no concretely defined basis for engaging with Forest. As a result, despite 6 years of demonstration of promising outcomes, Forest still has little or no engagement with the public sector and has therefore had to be entirely self-sustaining and self-sufficient.

This is also true of involvement with any agencies that are used to engaging with a more traditional/institutional setting. Forest provides an open environment which promotes autonomy. Often referring professionals are looking for a more structured and, they believe, secure environment in which to place their "patient" and they may not believe that an environment such as that at Forest is sufficient to maintain them in care.

A focused effort to obtain quality accreditation (healthcare specific ISO9001:2008) was viewed as crucial because of this sense of existing somewhere between all other therapeutic entities and not falling straight into any one pre-defined box. Attainment of international quality standards, which requires comprehensive and on-going review of standards across all areas of the organisation. resulted in achievement of that accreditation.

Monitoring treatment integrity on an on-going basis is time consuming and challenging to staff. Provision of coaching and feedback is a wonderful thing, when staff look for it; the sense of imposing it however creates a very different dynamic. Furthermore, it is virtually impossible, and possibly ineffective, to ensure that only MI takes place, especially when the primary therapists are well trained and experienced psychologists with more tools in the box. Therefore, although the programme was planned as a pure MI treatment process, in practice aspects of other models are incorporated by staff members. Therefore, it is most accurate to say that the primary governing approach of the Centre is MI, and all therapy is MI adherent, but other models may be utilised on a case-by-case basis.

Finally, as with any structured treatment programme, there needs to be flexibility to meet the needs of individual guests. As detailed above, the programme includes a 6th session milestone process that has proved to be powerful and beneficial in terms of strengthening commitment. However, not every guests is ready to go into phase 2 at session 6, and indeed some are in phase 2 before they even contact Forest. Therefore, Forest has developed a broad interpretation of this process; whilst most milestones do take place on session 6, some do not, and in some cases they may not take place at all.

CONCLUSION

Forest Treatment Centre uses an evidence based, MI dominant approach, investing trust in its guests and facilitating guests' articulation of their reasons for being there and their reasons for wanting to make treatment work. Forest guests are retained at remarkably high rate and appear to do very well; the likelihood of successful change (as reflected in the independent outcomes analysis) appears to be superior to the norms in these treatment areas. Our understanding of why this is so can be summarised thus:

- When people are treated as responsible and dignified adults they tend to act as such.
- When people are trusted they tend to make better decisions.
- When agents of treatment promote autonomous involvement with change, the likelihood of perceiving it as a safe prospect is higher.
- Thus people are more likely to openly discuss their concerns, reflected not only in the clinical conversations, but indeed in the whole environment (exploring ambivalence).
- When there is no pressure exerted externally to abide by a programme structure, people are more likely to choose to engage and thus benefit more from it.
- The sense that they have come through a process of change because they have decided to do so safeguards against a

ISSN 2160-584X (online) Vol. 1 No. 1 (2012) DOI 10.5195/mitrip.2012.13

catapulting effect of leaving a safe, cocooned treatment environment to being back in their old environment free to decide for themselves (this freedom was never removed).

- Skilled therapeutic response to developed articulation around reasons, need and ability to change (change talk and commitment language) is key to strategically helping people dramatically increase in their sense of drive and strength to implement change and simply find a way (with full practical and emotional support).

The Forest experience blends motivational Interviewing (its spirit, principles, and in therapy its techniques) inside the therapy context and also outside of it, and a holistic environment that pays specific attention to general well-being and the development of self efficacy. The result is a pleasant environment, where guests can take the opportunity to attend to developing a sense of inner peace whilst availing themselves of a highly focused therapeutic programme with only one simple goal: increasing the likelihood of successful change.

ISSN 2160-584X (online) Vol. 1 No. 1 (2012) DOI 10.5195/mitrip.2012.13

Motivational Interviewing MITRIP
TRAINING · RESEARCH · IMPLEMENTATION · PRACTICE

Welcome to *Features and Communications*

Claire Lane

Dear Readers,

Welcome to the *Features and Communications* section of *MITRIP*. Here you will find the 'magazine' section of the journal. The tone of this section is informal. It seeks to foster the engagement and involvement of you, the *MITRIP* reader. It's also a forum for you to tell us your thoughts about what has been published in *MITRIP*, to communicate with other MI-minded readers, and to keep others informed of the latest MI related news.

You will see that our section currently has two subsections. The first section, The Office, will contain our letters to the editor regarding articles published in previous editions of *MITRIP*. It will also contain reviews of books and other MI training resources that may be of interest to you. Finally, we will have news in brief to keep people up to date with MI related developments. What are your thoughts on what you have read in this edition of *MITRIP*? Do you have any news you want to share? Get in touch with us and let us know!

Our second section, The Lounge, is much more informal and entertaining. Do you have an MI dilemma? Perhaps our spoof 'agony aunt' Iris will be able to help you out with that (she can be MI consistent, but also incredibly directive!). Could you contribute an article with an MI focus that is not necessarily a training or research study in itself, but is topical and interesting to read? In this edition, for example, Chris Dunn and colleagues have contributed a humorous but topical piece about coding and measurement, which we hope you will enjoy.

There is more to come in future issues, too. We hope to introduce a third section, The Classroom, in the next issue. We want to encourage undergraduate and postgraduate students to submit contributions about their experiences of learning MI, and to review learning materials they have used. This embraces *MITRIP's* value of encouraging contributions from everybody. We value what readers who are at earlier stages of their professional development have to say as much we do the views of as those of us who are further along that road.

I'll sign off now just by saying that we hope you enjoy the content of this section, and that we look forward to hearing from you by the next issue. Please feel free to contact me on clairelane1978@gmail.com.

With best wishes,
Claire Lane
Section Editor

ISSN 2160-584X (online) Vol. 1 No. 1 (2012) DOI 10.5195/mitrip.2012.14

Motivational Interviewing MITRIP
TRAINING · RESEARCH · IMPLEMENTATION · PRACTICE

Ready, Willing and Able

One DVD
Pip Mason and Chris Butler
Churchill Livingstone, 2010
Available at www.pipmason.com
£46.20 (GBP)

Review by Moria Golan, PhD[1]

As an MI trainer, academic lecturer and researcher, I always look for new ways to demonstrate learned material. In my favorite course, "Therapeutic Communication," I train clinical dietitians in the theory and practice of counseling skills, sharing the challenges I face when treating patients with weight-related problems (mainly eating disorders) in a community-based setting. I also train professional groups from different disciplines (mainly MD's and RD's) to integrate various strategies in their every-day work in the prevention and management of various health issues.

The biggest challenge I face when using videos in my training is to ensure that the scripts, dialogue, and atmosphere are authentic and representative of real life to a multicultural audience whose mother tongue is not English.

The purpose of this DVD is to illustrate patient-centred approaches to health through a video scenario and accompanied workbook. The style of the structured consultation demonstrated is explored in *Health Behavior Change: A Practitioner's Guide* by Pip Mason, a nurse, and Chris Butler, a primary care physician (Churchill Livingstone: London, 2010), who are both based in the UK.

The First DVD includes instructions on how to use the pack, a workbook, course handouts, and discussion sheets for all six scenarios illustrated in the second DVD.

The second DVD portrays six unscripted scenarios (10-18 minutes), all in health care settings. Each scenario is accompanied with clips of specific strategies demonstrated in those scenarios: establishing rapport, agenda setting, exploring importance and confidence, rolling with resistance, exchanging information as well as feedback and comments from patients and health practitioners. Pip Mason and Chris Butler play the health practitioners, and professional actors play the patients. They discuss the management of poorly controlled asthma, depression, constipation, unprotected sexual activity, heavy alcohol intake and an overweight child. Steve Rollnick served as the pack's consultant.

This pack is a helpful tool for those who wish to develop their own skills in conducting behavior change consultations as well as for those who teach counseling skills and wish to illustrate the learning material, spirit, skills, and practices with various scenarios. The five-page handout can be distributed for background reading.

The DVD is of high technical quality. The combination of scenarios and discussion sheets, which offer questions that can be used for subsequent group discussion, provides a unique learning experience. For lecturers it is a very convenient tool whereby the clips eliminate the need to go back to the video and look for specific strategies. The illustrated scenarios sound authentic and are not too dramatic, in contrast to other videos I have used in my teaching, which received complaints as seeming too artificial and unrealistic to mirror the clinic's true reality.

However, I feel that the resource could have been further improved if the producers had used a more authentic setting to picture it—a real community outpatient clinic room, for example. It also lacks the practices and strategies tags (open question, simple reflection, etc.) which often help the audience to focus on the practices presented rather than follow the script per se.

This pack teaches the art of counseling skills, providing the opportunity to study with master teachers. It includes authentic role playing, illustrating a structured and easy-to-follow counseling style. Of special merit is the accompanying material with background information and discussion sheets. This pack might be a helpful learning tool for health practitioners to refresh and continue their learning after attending a training workshop. It can also be used by lecturers and trainers from different cultures to be shown as part of a course, accompanied by explanation and discussion.

[1] Shahaf, eating disorders community-based facility, Hebrew University of Jerusalem and Tel Hai Academic College, Israel. Email: moriag@netvision.net.il

ISSN 2160-584X (online) Vol. 1 No. 1 (2012) DOI 10.5195/mitrip.2012.16

Motivational Interviewing MITRIP
TRAINING · RESEARCH · IMPLEMENTATION · PRACTICE

Guidance for Learning of Motivational Interviewing

A Resource for Trainers

Four DVDs of a three-day training
Steven Malcolm Berg-Smith, recorded December, 2008
Available at www.berg-smithtraining.com
$100.00 (US)

Review by David Prescott, LICSW[1]

Years ago, when first studying motivational interviewing with Steve Berg-Smith, I lived next door to an elementary school baseball coach. Fascinated by the idea of coaching, but having no competence in sports whatsoever, I asked, "If you could only have one skill for assessing and improving baseball players, what would it be?" His answer was, "Study what they do with their feet."

It took months for me to see the wisdom of his answer. I was expecting something about inspirational pep talks. The coach knew that the best way to help aspiring baseball players was to set the conditions for them to learn to stand and move correctly. In this coach's mind, collaboration and building autonomy simply came with the turf. His chief daily concern was in evoking and awakening the best behavior in his students so that they could see their own progress.

This set of DVDs is our opportunity to study an excellent trainer. Steve Berg-Smith truly embodies the "spirit" of MI, and his trainings offer a unique experience. He consistently connects with trainees, remains focused on their learning, and models MI at every turn. However, unlike being in the room and the moment, these DVDs provide insight into how Berg-Smith does it. Metaphorically speaking, these DVD's make it possible to study what he does with his feet. There are many helpful MI DVDs. This is the only DVD resource for trainers that focuses on the training process itself and not simply MI.

The DVD set begins with eight important guidelines for providing training (not to be confused with the eight-step model of learning MI). Steve boils these down to their essentials. Even his description of these principles exemplifies them in action. They include:

1. MI is also a style for training.
2. Model, model, model motivational interviewing from the beginning to the end of training.
3. Keep it simple. Less is more.
4. Decrease content, increase involvement.
5. The trainer is the most powerful visual aid, not the slides.
6. The wisdom is in the room.
7. Make it multi-modal.
8. Expect and respect the unexpected.

Steve's brief explanation of this nexus of style and principles is not only concise, but he delivers it in a style that is completely consistent with the content. On its own, it provides guidance to any trainer who wishes to deepen their trainees' experience. As one might expect from someone who spends his days and nights honing his skills, Steve's insights in this area provide a reference standard.

The DVDs then proceed through what many trainers would expect: a healthy dose of MI spirit, the four basic principles, OARS, drumming for change talk, responding to change talk, etc. The set includes larger group discussions, but not the copyrighted movie excerpts and small group exercises. However, the viewer does see Steve as he circulates through the room responding to questions. In some situations, high-speed playback provides a sense of the overall feel of the live program.

There are a number of strengths in this set of DVDs. MI trainers know the importance of the trainer-trainee nexus well. Steve has clearly worked to capture it. This is clear in some of the smaller details. For example, in one segment he works with a trainee who is thoughtful and bright while appearing determined to gain others' attention. Steve's graceful handling of her provides a better experience for all. The opportunity to watch Steve, with the option to stop, rewind, and watch again means that the pearls (for example, Steve's brief but powerful discussion of ambivalence) that might otherwise escape our attention are now available for deeper study. While DVDs often lose much of the magic of the moment, this resource is a rare exception. Steve's own motivation for this work shines through in every moment, providing an excellent inspiration for who we can be when we are guiding others.

At the same time, there are some weaknesses. Some of the microphone and camera placement make it difficult to hear and see many of the attendees, making some of the learning process difficult to absorb. Likewise, Steve possesses a great talent at using materials such as bells, shakers, and posters to heighten the learning experience. It would have been helped if Steve gave the viewer a brief tour of these materials and his recommendations for their best use. DVD resources such as this are notoriously difficult to produce, and so this project's shortcomings must be understood in that context.

This resource is essential for all who provide MI training. For newer trainers, this resource provides an excellent format and ideas for making the training experience come alive. For more seasoned trainers, Steve's carefully honed statements and examples will provide new ideas. However, as effective as these DVDs are as a resource for trainers, they are not intended as a resource for learning MI, and so professionals entering the world of MI will want to start elsewhere.

[1] P.O. Box 6021, Falmouth, ME 04105. Email: vtprescott@earthlink.net

ISSN 2160-584X (online) Vol. 1 No. 1 (2012) DOI 10.5195/mitrip.2012.17

Motivational Interviewing
TRAINING · RESEARCH · IMPLEMENTATION · PRACTICE
MITRIP

A *Rediscovered* Ancient History of Motivational Interviewing and its Measurement

Christopher W. Dunn, PhD[1], Sarah Peregrine Lord, BS[1], Jessica Lowe, BS[1], Jutta Joesch, PhD[1], David C. Atkins, PhD[1]

Abstract

We wrote this piece for coding teams around the world, hoping to raise some measurement issues, to inspire, and to entertain (perhaps not in that order). This one's for you, coders and for you, trainers of coders, you who work so hard to measure Motivational Interviewing using the standardized coding systems such as the MISC, MITI, and SCOPE.

Keywords

motivational interviewing, coding

SETTING

We are transported to ancient Pompeii (79 CE), where a spirited dialogue ensues in the sunny town square, between Epistemopheles and Methodia, two collaborative colleagues in search of Truth.

ACTORS

Epistemopheles, formerly a "rock star" among Greek philosophers, has recently moved to Pompeii, having been ostracized from Greece for his hyper-empirical epistemology (theory of knowledge). He is infamous for having once said, "If you can't see it, touch it, or smell it, it ain't there." He wears a dusty philosopher's robe.

Methodia, a social scientist who once spent a year in meditative seclusion developing "Motivational **Intra**viewing," the ancient method for privately changing one's own bad habits using self-centered listening and directive self-talk. She is eager to share with Epistemopheles and hear his ideas about a new turn she has recently taken in her work. She wears an ancient stethoscope for listening to her own heart.

Statisticuss, a wizened gentleman who mysteriously appeared one day in Pompeii calling himself "Doc." The town renamed him "Statisticuss" for his absurd belief that complex interpersonal interactions could actually be measured. The Pompeii gossip was that he may have come from another time.

DIALOGUE

EPISTEMOPHELES

How good it is to see you again, Methodia my friend! First, let me express my deepest appreciation to you for having developed Motivational **Intra**viewing. Although we philosophers have long thought that bad habits result from false knowledge, until now nothing could be done about it! I recently used Motivational **Intra**viewing for my own obsessive pontificating. I found that listening to my own ambivalent self-talk was so annoying that I was able to significantly reduce this behavior!

METHODIA

Almost as if your self-reflection nourished that tiny pedantic caterpillar inside of you to emerge as a beautifully socialized butterfly!

EPISTEMOPHELES

Exactly! Wow, you really understand…

METHODIA

Well, thank you for affirming my efforts to develop this method, Epistemopheles. That certainly boosts my confidence! Anyway, I could never have developed Motivational **Intra**viewing without our collaborative dialogues! The way you acknowledged my abilities and autonomy to make up my own mind evoked much motivation within me. Indeed, it was the experience that two heads are better than one that has recently taken my work in a new direction.

EPISTEMOPHELES

(Quiet and eliciting.) Tell me a little bit more about that.

METHODIA

Wow! Something about the way you said that just really frees me up to tell you more. Hmmm...

(Pulled into a soft-focus flashback.)

One day, while alone in my lab developing the intra-method, I suddenly realized that all that self-focus had left me feeling incredibly isolated… always staring inward. I felt lonely and incomplete…yearning for change but unable to find my pulse of readiness… One day I realized that I was going insane from all that time alone, so I finally went outside and began talking to people in the town square about my bad habit of isolating. I noticed that some of those people listened to me in a manner that made me believe that I could change, but others had a manner of being with me that pushed me away from change and made me feel helpless and hopeless.

[1] Department of Psychiatry and Behavioral Sciences, Harborview Medical Center, University of Washington

Special thanks to Terri Moyers, Douglas F. Zatzick, Craig Fields.

The authors have no conflicts of interest to report.

Correspondence concerning this article should be addressed to: Christopher W. Dunn, PhD. Email: cdunn@uw.edu

ISSN 2160-584X (online) Vol. 1 No. 1 (2012) DOI 10.5195/mitrip.2012.20

(Emerging from flashback.)

So, my friend, I have discovered that certain listeners can help someone find their own way of changing—a way of change that couldn't have been articulated in isolation!

EPISTEMOPHELES

(Lightbulb moment.) If I may be so bold as to complete your paragraph, it appears that you have discovered Motivational **Inter**viewing!

METHODIA

Exactly! Hmm…Motivational **Inter**viewing? Not the sexiest name for something so exciting.

EPISTEMOPHELES

Well, maybe you could call it "My MI" for short? It's a snappy name, and you could get the credit?

METHODIA

I dunno, I'm trying to get away from that self-centered stuff. How about we just call it "MI" and then spice it up with some acronyms?

EPISTEMOPHELES

Darn. See, the ideas you come up with on your own are way better than any advice I could ever give you!

METHODIA

And yet, it is you who are collaborating with me and evoking these ideas; I am freed to think about things in ways I couldn't have found alone…

EPISTEMOPHELES

Hmmm….So far, you have observed that at least in your case, two heads are better than one, as long as one listens to another in a particular manner. As I think about it, you must be wondering what other bad habits MI might help with.

METHODIA

Great summary, Epi. And yes, I do indeed plan to test MI for high-risk ouzo consumption.

EPISTEMOPHELES

But if it seems to work for ouzo, how will you KNOW with any degree of certainty that the particular MI manner was indeed used by counselors and not some different manner of listening or speaking? In other words, how will you differentiate between manners?

METHODIA

Hmm. I suppose someone would have to listen to measure the counselors' talk!

STATISTICUSS

(Jumping out from the nearby bushes wearing 3-D glasses and holding a test tube, calculator and rubber chicken.)

Surprise! Greetings, ancient philosophers!

METHODIA and EPISTEMOPHELES

Gasp!

STATISTICUSS

I have been following your dialogue from the bushes and it seems Methodia has discovered that the *manner* in which one listens to others' ambivalence about their bad habits can influence whether that person changes! Indeed, your dialogue is uncannily similar to one that I was just spying on in Norway where students are evoking the same thing from a kindly gentleman with a red beard. They hope to be able to measure some of this stuff too! The idea is simply to write the rules for MI and then score the counselors on how well they adhere to those rules.

METHODIA

Simple?

EPISTEMOPHELES

Norway?

STATISTICUSS

Oops, never mind…I must have jet lag or something. Anyway, during these many weeks of listening to different dialogues, I have worked out a way to measure MI so that it can be tested and taught.

EPISTEMOPHELES

Well, Statisticuss, first off, if it's okay with you I'd like to share that I'm a little creeped out that you have been watching us from the bushes all this time. On the other hand, your ideas are intriguing. I suppose one could write rules that define the elements and style of MI, a yeoman's task in and of itself. But assigning numbers to human discourse is akin to looking through a dense MISC. The SCOPE of potential disagreement and the many potential sources of error are MITI daunting!

STATISTICUSS

Well, you sound a little surprised by this whole thing. If you don't mind, I have a couple of ideas about a TOOL for measuring MI that I call a "rating system." And the people using that tool to measure discourse are called "coders" because they will "code" utterances by speaker and listener to certain categories.

EPISTEMOPHELES

Harumpf. Call it anything you want, but you can't make a tool that measures an interpersonal interaction; nobody can measure TALK!

STATISTICUSS

Maybe, maybe not. But if we don't at least try to do so, how will the world know if someone is doing MI or not? So, with your permission, I would first like to describe how such a tool would be used, because form follows function.

EPISTEMOPHELES and METHODIA

Okay, sure.

> "It is important to apply a standardized coding system for monitoring MI style and technique, so that skill level vs. outcome can be analyzed... Miller is currently developing a standardized coding system which was not used by any of the 29 studies under review, so we are less certain that the style of MI was captured by these studies than we are the techniques." [1]
>
> "It is imperative that an effort is made in future studies to describe precisely how motivational interviewing education is performed and how to use the methods in client counselling, allowing us all to learn more about how to increase and maximise its effect." [2]

STATISTICUSS

The first thing an MI rating system must be able to do is to *differentiate* between what is truly MI and what is not MI. That's the most basic need for such a tool, because, for example, if you use an MI style of counseling with a risky ouzo drinker, and later they drink less ouzo, how

ISSN 2160-584X (online) Vol. 1 No. 1 (2012) DOI 10.5195/mitrip.2012.20

do you know that it was MI that worked and not something else? In other words, the first question to ask is, can MI be differentiated from other ways of counseling?

EPISTEMOPHELES

Granted.

STATISTICUSS

(Musing.) Hmmm, something like Project MATCH might provide the opportunity to answer that one…

METHODIA

Huh, Project MATCH?

> Project MATCH included a motivational interviewing intervention and "treatments were discriminable in that therapists…rarely used techniques associated with comparison approaches." [3]

STATISTICUSS

Don't worry. All in time, all in time. So as I was saying, if you were to find that MI cannot be clearly differentiated from other forms of counseling, you would close up shop and stop developing your measuring tool, because you would have learned that MI isn't different enough from other styles or that MI cannot be detected by coders. But suppose you found that MI is indeed unique and easily differentiated from other forms of counseling. In that case, you must begin to study if MI works. And while you are doing that, you must develop a "gold standard" for MI…

Here's the deal: if the impact of MI is being tested with different bad habits and different types of people then every study ought to collect MI scores for each counselor. Once many scores have accumulated for many different counselors you will eventually know *how good counselors must be at MI to be effective. That will be your gold standard.* If you do not do this, you will soon be facing a conundrum in which hundreds of studies may have shown that MI works, but nobody will know which elements of MI were actually done nor how good those counselors were at performing those elements. That would get messy because the world will soon be clamoring to learn MI, but nobody will be able to tell them how well one must do MI in order to change bad habits.

> "…few studies have detailed how interventionists were trained, provided documentation of the fidelity of delivery of MI, or included process measures to relate to outcomes." [4]

There's no way around this first step. Early on, you must establish norms for people who perform MI, or it won't make much sense to ask how good someone is at MI, because there will be nothing to compare them to.

METHODIA

Norms?

STATISTICUSS

Yeah, norms are very cool numerical scores that tell you whether your MI skill is at, above, or below average compared to all other counselors. But norms also tell you what proportion of that normative sample are above and below your score. Very handy scores, those norms.

At the very least you should establish norms for the population of counselors in scientific studies (presumed to be highly skilled in MI) and establish norms for the population of community counselors (assumed to be less skilled). That way, you could meaningfully evaluate how good a given counselor is compared to the norms of two other populations. Eventually, thresholds could be established to compare MI efficacy. That way, trainers wouldn't have to guess whether their work is good enough, or go back and try to establish those quality benchmarks after the fact.

EPISTEMOPHELES

Well, Statisticuss, I would I agree that you *might* be able to design a rating system that differentiates MI from non-MI. But I am less confident that you will be able to design a rating system that can measure *whether one counselor is better at MI than another counselor.* That is a much tougher measurement task. I say this because the difference between the scores of a counselor doing MI and the MI scores of a counselor doing something else is probably very large, since after all, the counselor not doing MI isn't consciously trying to adhere to MI spirit or technique. But the difference in MI scores between two different counselors who are both trying to do MI is likely to be much smaller and therefore harder to detect with measurement. It's easier to differentiate a cow from a goat than one goat from another goat.

STATISTICUSS

Agreed, Epistemopheles! It won't be easy. Nonetheless, I would suggest counting the occurrences certain MI behaviors. And because some things can't be captured by a behavior count I would throw in a few global rating scales to represent the overall style of the counselor. Things like your tone, or the way in which you be with the other person, you know, some measure of their, their…

EPISTEMOPHELES

(Excited.) Their "be-ness?"

METHODIA

You're going to measure their *WHAT?*

STATISTICUSS

Trust me, I would call that one "spirit" so as to avoid future misunderstandings. We could define it as the way a listener is being when they foster a relationship that allows another person to think about and welcome change- a way of being collaborative, evocative, and supportive of autonomy.

EPISTEMOPHELES

And you think you're gonna MEASURE all that stuff?

METHODIA

Your second confront today! Oooh, let's put that one on the behavior list, because it will help to identify ways of being that are not MI consistent! Statisticuss, please say more about these coders. How many of them would I need?

STATISTICUSS

It is usually better to have more than one coder, for logistical reasons. One advantage is that two coders can finish the job in half the time. Also, it can take about the same amount of time to train three or four coders as it does to train only one or two. More than one coder allows for a certain amount of friendly competition, dialogue and support while learning the coding system. Just as Methodia has discovered that two heads are better than one, the same is true when it comes to coders following the MI scoring rules to the greatest possible degree. Two people can talk their way to a better understanding of the coding rules than one coder can alone. Just make sure that they don't get too carried away when debating coding discrepancies. Remember, no "true scores" exist, so coders should hold the attachment to the codes lightly, use the coding

ISSN 2160-584X (online) Vol. 1 No. 1 (2012) DOI 10.5195/mitrip.2012.20

guidelines to resolve discrepancies and defer to the trainer when utterly confused. Coders should try not to overthink any utterance. When in doubt during a coding discrepancy, each coder should reference the coding guideline that he or she thinks applies, and then simply apply that rule as consistently as possible. Rather than obsess or ruminate, coders must learn to "guess n' go." Finally, trainers should intervene if coders become hostile during utterance discrepancy discussions (e.g., challenging each other to duels or lobbing water-balloons into adjacent cubicles).

METHODIA

So having more than one coder is the best way of keeping each other honest and pushing each other to interpret coding rules as rigorously as possible.

STATISTICUSS

Right. There is also a statistical advantage of having more than one coder. It is easier to establish intercoder reliability because the correlations between sets of scores will be stronger the more raters you have. It's a mathematical thing. Speaking of math, you should probably use intraclass correlations to calculate intercoder agreement on the behavior counts, but don't use them for calculating intercoder agreement on the global ratings. For the globals, use this absolute agreement rule that will one day become popular: on the 5-point global rating scale, any two raters should not differ by more than one point for 80% of their common ratings.

If the coders reach high agreement and interrater reliability, it is more likely that they have been able to consistently apply the coding rules across the coding team. If there are still too many inconsistencies--within each coder's ratings or between coders then it is likely you will not have high intraclass correlations on behavior counts, or absolute agreement on the global ratings. So even though there can be some risk that they are agreeing in the wrong application of the coding rules, *the process of reaching agreement through expert-facilitated dialogue* is your best bet for removing what we call "measurement error."

METHODIA

So in other words 80% of all pairs of global ratings must be within one point of each other?

STATISTICUSS

Yup. And one more thing about those intraclass correlations. Some scientists will tell you that they must be .6 or above for adequate intercoder agreement. But each of those correlations also has attached to it a confidence interval, and the 95% confidence interval shouldn't be any larger than….

EPISTEMOPHELES

Whoah! What is that rumbling I hear?

METHODIA

Oh, that's just Mt. Vesuvius, our very old, inactive volcano, don't worry.

STATISTICUSS

Despite one's best efforts to be accurate, there is always some measurement err… is that the floor shaking?

METHODIA

Vesuvius seems pretty feisty today.

STATISTICUSS

That thing is gonna blow!!!

(Statisticus jumps into his DeLorean with flux-capacitor and disappears with the knowledge of Motivational Interviewing and coding.)

EPISTEMOPHELES

Egads! A shiny horse zooming through the air! Wait, where did that Statisticuss go?

(Volcano explodes.)

METHODIA

I could be wrong, Epistomopheles, but I fear that we are in danger. What are your thoughts about moving to safer ground?

EPISTEMOPHELES

FORGET SPIRIT! RUN FOR IT!!!!!

EPILOGUE

NARRATOR

Alas, dear reader, Epistomopheles, Methodia, and their fine work were buried forever beneath a blanket of fiery ash, never to be seen again.

We have learned from this rediscovered ancient history that psychotherapy coding is not without problems. Will your analysis be at the utterance level? Paragraph? Talk turn? Thematic level? How will you decide which speech units to measure? What if you fail to specify the best speech units for understanding MI's effectiveness? After all, nobody before us has ever coded everything in MI to see what actually causes the change. And if you leave something behind, it will never get measured, noticed, or taught by MI trainers.

Psychotherapy coding is not without its problems. First, a coding system must choose only one speech unit for analysis, leaving behind all others: will your analysis be at the utterance level? Paragraph? Talk turn? Thematic level? And what if you fail to choose the best one for understanding MI? Another problem looms when one is forced to choose which codes to include in a coding system and which ones to abandon. Although one hopes to include only the ones that cause change, we don't know which ones those are, because after all, nobody before us has ever coded everything in MI to see what actually causes the change. And if you leave something behind, it will never get measured, noticed, and then taught by MI trainers.

Finally, there is the issue of reductionism, whereby one pays a necessary price for the luxury of condensing or reducing many words (the MI interview) down to few words (the codes). This reduction necessarily risks losing the meaning, intent, or tenor of the encounter. Let us hope that Statisticuss, the gentleman with the red beard, and his collegues can work something out…

ENDNOTES

[1] Dunn, C., DeRoo, L., & Rivara, F. (2001). The use of brief interventions adapted from motivational interviewing across behavioral domains: A systematic review. *Addiction, 96,* 1725-1742

[2] Rubak, S. (2005). Motivational Interviewing: A systematic review and metaanalysis. *British Journal of General Practice, 55*, 305.

[3] Carroll, K., Conners, G., Cooney, N, DiClemente, C, Donovan, D, Kadden, R., Longabaugh, R., Rounsaville, B., Wirtz, P., & Zweben, A. (1998). Internal validity of Project MATCH treatments: Discriminability and integrity. *Journal of Consulting and Clinical Psychology, 66,* 290.

ISSN 2160-584X (online) Vol. 1 No. 1 (2012) DOI 10.5195/mitrip.2012.20

[4] Burke, B. L., Arkowitz, H., & Dunn, C. (2002). The efficacy of motivational interviewing. In W. R. Miller & S. Rollnick, *Motivational interviewing: Preparing people for change* (2nd ed.) (pp. 217-250). New York: Guilford.

ISSN 2160-584X (online) Vol. 1 No. 1 (2012) DOI 10.5195/mitrip.2012.20

Motivational Interviewing
TRAINING · RESEARCH · IMPLEMENTATION · PRACTICE
MITRIP

Dear Iris

Dear Iris,

For some time now, I have been fascinated by the concept of 'the spirit of MI'. It seems such a fundamental part of the approach, yet at the same time, so unspecific. Although described as 'collaboration, evocation and respect for autonomy' by Miller and Rollnick, it seems to me that it cannot be as simple as that. There simply must be more to it, and I feel that I need more in order to understand it and put it into action. I have therefore dedicated my life to a quest, searching for the true spirit of MI.

My quest has taken me to distant lands. I have travelled far and wide, and visited the wise members of several exotic tribes. 'Oh wise ones,' I pleaded, as if my life depended on it. 'What is the secret to truly embodying the spirit of MI? The resolution of my clients' ambivalence depends upon it.'

Their answers were diverse. On the suggestion of one Shaman, I spent six months in solitude in a cold dark cave against my will, to truly experience the misery of feeling trapped and unable to do anything about my situation. One wise elder suggested that sucking mints and drinking mint tea would cleanse the body, and give it a distinct mintie flavour. Another suggested that I needed to embody the essence of my forefathers in order to experience the spirit of MI, and that dying my hair red, growing a beard, and speaking with a South African accent should do the trick.

Iris, I have tried all their suggestions, and none of them seem to have worked for me. Although admittedly my South African accent could probably do with some more work, I have given them all a really good shot. However, I still feel that I have little understanding of the true spirit of MI. I feel that my efforts have not been worth it, and that others laugh at me. They do not fully appreciate how hard I have been working.

I have reached a point where I am on the verge of giving up my quest. However Iris, oh wise one, I thought that perhaps you may know the answer. What is the true spirit of MI, Iris? Please help me.

Yours hopefully,

An explorer of ambivalence

Dear Explorer,

It certainly seems that getting to grips with MI spirit is something that is really important to you. You have made so much effort to increase your understanding, and have gone to lengths that most others would not have had the ability to do. You were able to use your initiative and persist, even when times were tough. It seems like your will is currently being tested to the limit, yet you remain dedicated in wanting to truly embody the spirit of MI.

I am struck though that you have sought the expertise of others to answer your question, when within MI, it is the client who is seen to be the expert. It also sounds like these experts were incredibly directive in telling you how spirit should manifest itself within you. In my experience, spirit is a very personal thing. It's about your way of being with others. The person who is best able to answer that question is therefore you. Perhaps choosing to explore deep within yourself, rather than seeking the opinion of others, will help you in finding out what the spirit of MI truly means to you.

Failing that, try the 'spirits' section of your local supermarket. You may well find the spirit of MI down there. I've heard that a spirit called 'creme de menthe' has a distinctive mintie flavour, so that may be a good starting point.

Yours affectionately,

Iris xxx

ISSN 2160-584X (online) Vol. 1 No. 1 (2012) DOI 10.5195/mitrip.2012.15

Dear Iris,

I am keen to get some help. I hope you will indulge me?

I have been a MINTie for over a decade now and attended several forums. This experience has been great. I have met many people and have observed changes in all of them following conversations with me.

What I have noticed is that I have spent most of my time eliciting information from other MINTies, so much so that I now have a tomb of logs of these coded conversations (the majority of which are MITI coded and score highly on skills and globals).

Everyone else is changing except for me. I am still busy gathering data on everyone and find myself obsessively eliciting-providing-eliciting without due regard.

My active listening skills are so good I can tune into all of the simultaneous workshops at the forums by simply standing in the reception area of the hotel. I find myself asking permission before speaking to anyone. I am so person centred I don't know where my own centre is anymore!

Help me to move on please. How do I get to be a self-determinist?

Yours,

A rounder with a pony tail, diabetes and a cigarette habit

Dear Rounder,

You are indeed not the first to question whether adopting MI as a way of life is healthy. I remember in the MINT Bulletin edition 13.2, Jake Rollnick shares some of his thoughts on this topic, and highlights the potential pitfalls of taking MI too far.

You say would like to move on. What would 'moving on' mean to you? How would life look if you did move on? What would need to change in order for you to be able to move on? I think perhaps if you started using your MI skills on yourself rather than on those around you, and focussed in on the spirit of the approach rather than the techniques, you might find it a little easier to get to where you really want to be.

Failing that, I suggest you just put in some ear plugs, shut your eyes and stop talking to people. That ought to solve the problem.

Yours affectionately,

Iris xx

ISSN 2160-584X (online) Vol. 1 No. 1 (2012) DOI 10.5195/mitrip.2012.15